2.2 SUB PROGRAMME: HIV/AIDS/STI/TB CONTROL PROGRAMME

The Gauteng AIDS Plan is an Inter-Sectoral AIDS Plan, involving all government departments and civil society sectors, funded through the Health Vote. The plan reflects the expanded AIDS response and is presented as necessary as two components:

2.2.1 SITUATION ANALYSIS:

Epidemiological Information

Sexually Transmitted Diseases (STD) management is being offered in 89% of clinics. The syphilis prevalence rate was 9.6% in 1999 and 2.7% in 2001 showing an 83% reduction over a 3 years period. The 2002 statistics will only be available during 2003.

TB incidence has increased from 304 per 100 000 population in 2000 to 315 per 100 000 population in 2001. The increase in the number of extra-pulmonary TB cases indicates the impact of the HIV/AIDS on the TB epidemic. The number of deaths has also increased (from 9% to 11%) as a result of the HIV/AIDS epidemic. The positive impact of our TB control programme is evident. The new smear positive conversion rate has increased from 66% in 1998 to 73% in 2001. The new smear positive cure rate has improved from 59% in 1997 to 68% in 2001. The establishment of Directly Observed Therapy (DOTS) in the communities has resulted in **94%** of TB patients being on the DOTS programme.

The HIV epidemic has stabilised in South Africa according to UNAIDS, although at very high levels. The HIV infection rates on ante-natal survey in 2001 was 29,8%.

Table: Baseline data on HIV/AIDS/STI/TB Control Programme

Condition		**1999**		**2000**		**2001**
	No.	**No. per 100000 people**	**No.**	**No. per 100000 people**	**No.**	**No. per 100000 people**
HIV antenatal seroprevalence	23.9%		29.3%		29.8%	
VCT uptake	-	-	-	-	15910	
PMTCT HIV positive HIV negative					 8677 21373	

Counselled /tested On nevirapine					30050 6752	
STI (total cases)	350700	3.51	301975	3.02	249155	2.50
Syphilis cases	9.6%(ANC surveillance)		5.1 %(of tested STI patients) 9.6% (ANC surveillance)		8.6%(of tested STI patients) 2.7%(ANC surveillance)	
New smear positive TB cases	11979	150	14157	173	14837	177
All TB cases reported	21281	270	24863	304	26371	315
PTB cases reported	16181	203	18208	223	19665	235

Behavioural surveys demonstrate change of risk behaviour amongst youth. The condom supply of 7 million per month supports this picture. There is large scale mobilisation of communities on AIDS. Youth organisations, schools, business, sex-workers, unions and hostel residents organisations make large contributions to prevention efforts. Effective interventions for reducing the spread of HIV are well developed internationally. Our challenge is to intensify prevention efforts to ensure a consistent drop in new HIV infection rates.

AIDS is now a familiar reality in all communities and workplaces, causing acute social problems and a load on health services. AIDS will continue to increase to 2010. Gauteng has relatively good levels of "openness" due to the sterling efforts of people who are living with AIDS. The basic health care services are provided on large scale: clinics, TB treatment, hospitals, VCT/counselling, support groups, home-care and hospice beds. The religious sector plays a leading role in care and traditional healers are involved on a large scale. These services need urgent strengthening to cope with the increasing AIDS load. Priorities include stronger management systems and training and support for staff. Increasing access to treatment with anti-retrovirals as part of a comprehensive package of care for HIV/AIDS is a key new challenge for the period 2002-5.

Orphans and children affected by AIDS represent the biggest and most long-term effect of the AIDS epidemic. Public awareness is now focussed effectively on this issue. The Department of Social Services leads the response involving a large number of departments and sectors. Basic services are in place: grants, social worker services and 22 local orphan support services. Lead projects such as Kutsong Home Care are showing real results, supported by government and mining companies. Communities make major contributions: the religious sector, traditional healers, civics, business and womens groups. Most schools also provide support – they are on the frontline of caring for children. Comprehensive services for children need to be expanded to scale over the next two years to ensure all children have access to services. The Department of Social Services lead this effort involving a large number of departments and sectors.

Table: Performance indicators for the HIV/AIDS/STI/TB control programme*

Indicator	Province wide value 200/02	By health district	National target by 2005
Input			
1. Total dedicated expenditure on HIV/AIDS activities	✓	✓	
2. Percentage of public PHC facilities** where condoms are freely available	90%	✓	100%
3. Percentage of provincial hospitals and fixed PHC facilities** offering VCT	15	✓	
4. Percentage of facilities of all types offering syndromic management of STIs	100%	✓	
5. Number of health districts using DOTS (with names)	6	✓	All districts
6. Number of TB/HIV health districts (with names)	✓	✓	
7. Percentage of TB cases with a DOT supporter	✓94%	✓	
Process			
8. HIV/AIDS plan formulated with stakeholders	✓		
9. Percentage of TB cases reported on	95%	✓	100%
Output			
10. Number of people trained in syndromic management of STIs	521	✓	
11. Smear positive PTB cases as percentage of all PTB cases	79%	✓	50-70%
12. New smear positive PTB cases as percentage of expected number of cases	69%	✓	70%
Quality			
13. Average TB specimen turn around time	61%	✓	< 48 hours
14. Percentage of TB cases who are being re-treated	15%	✓	6-8%
15. Percentage of new smear positive PTB cases who interrupt treatment	13%	✓	<10%
Efficiency			
16. Percentage of dedicated HIV/AIDS budget spent	✓	✓	100%
Outcome			
17. Antenatal HIV seroprevalence rate	29.8%	✓	
18. Syphilis prevalance rate at sentinel sites	✓		
19. PTB smear conversion rate at 2 months for new cases	68%	✓	> 85%
20. PTB smear conversion rate at 3 months for re-treated cases	50%	✓	> 80%
21. Percentage of new smear positive PTB cases cured at first attempt	68%		> 85%
22. Percentage of TB cases that are MDR	1%		< 1%

✓ Data still being collected or verified

Appraisal of existing services and performance during the past year

The Gauteng Inter-Sectoral Aids Strategy guides the implementation of HIV/AIDS programmes in this province. This strategy was informed by;

- National AIDS Strategic and Plan 1994 (reviewed '97)
- National Strategic Plan on HIV/AIDS/STD 2000-2004
- Three Reviews conducted in 2001/2 highlighting the strengths and weaknesses of the GautengAIDS response and provided more detailed guidance on strengthening the Health Sector response.
- The Gauteng AIDS Summit conducted in October 2002 re-inforces this picture.

The expanded response on HIV/AIDS epidemic

The 2001 HIV ante-natal sero-prevalence survey was 29.8% in 2001, with no statistically significant increase and hence stabilisation of the epidemic. The point prevalence estimates by age group indicate that the greatest increase is for the 20-35 years and 45-49 years age group. However, the rate for the under 20 year olds has not increased.

All provincial government departments play a role in implementing the Gauteng Intersectoral AIDS Programme, together with non- governmental organisations (NGOs) and People Living with AIDS.

The major highlights of achievement of the programme are as follows:

Social mobilization and communication

This programme aims to reach the entire population through cultural activities ,campaigns, role modelling , leadership and media. Through conventional advertising, 8.7 people million are reached per month (1.8 million through radio, 2.4 million through print, and 4.5 million through outdoor advertising). In May 2002, 8000 volunteers participated in the door-to-door campaign during the "Care Week". Quarterly meetings are held with NGOs, CBOs and intersectoral organisations. World AIDS Day Campaign 2002 is underway with 450 trainers and 10,000 volunteers trained.

Prevention

As part of the Youth strategy life skills programmes are implemented in 90% of schools, which reach 1.3 million youth annually. A total of 8000 teachers have been trained in Lifeskills.

- The Cultural programme operates in 41 hostels
- STI management (syndromic) is implemented in 90% of clinics

- An average of 7 million condoms is distributed per month.

The Gauteng Provincial Government workplace programme, which involves most Provincial Departments and supports 150 private sector companies, has been approved at

- the EXCO Retreat in May 2001 and there has been significant progress in implementation activities.
- 20 Voluntary Counselling and Testing sites (VCT) have been established in the province.
- Out of 15 910 people tested, 32% were positive. 241 lay counsellors and 173 professional health workers were trained. The Prevention of Mother to Child Transmission
- Programme (PMTCT) now covers 100% of public hospitals and 75% of Community Health
- Centres. 60% of pregnant women seen at public health facilities in Gauteng agreed to the HIV test and 32% of those tested were found to be positive.

Gauteng has prioritized mining towns and the inner city of Johannesburg because the social conditions in these areas maximize the spread of HIV. Programme co-ordination is de-centralised to Municipalities to increase effective local co-ordination of the inter-sectoral programme with community involvement. All six Municipalities have taken on this role following municipal elections in 2000. Merafong and Johannesburg illustrate how all the sub-programmes and services come together in a local area

Care

Funding is provided to Home Based Care (HBC) projects and support groups for People Living with AIDS (PLWA) to provide home-based care, support services and other related services. 470 caregivers have been trained and additional 150 people trained at the HBC conference.

Apart from the home-based care services, funding is provided for hospice beds across the Province. 200 step down beds have been established in six provincial hospitals. In addition, the Department funds 1495 beds for TB patients: the commonest serious opportunistic infections experienced by AIDS patients.

More than 80% of local clinics provide basic AIDS care, counselling and HIV tests as well as Sexually Transmitted Infections (STI) services. A total of 3 000 clinicians have been trained in clinical protocols.

From 2000/01 financial year the National and Provincial Leadership have prioritized children through the leadership of Department of Social Services 22 new orphan support services have been set up within 18 months. These support services identify children in need, place children with guardians, organize grants, provide material assistance and support child-headed households. Kutsong Home-based care in Merafong is a lead project supported by the province and Anglogold. Over 95% of 800 orphans absorbed into local families

Programme Organisation

- The Premier continues to provide political leadership that both profiles the epidemic and a comprehensive response to it. The Premier's Committee on AIDS and Gauteng AIDS Council meet quarterly and continue to provide the leadership necessary to fight the epidemic.
- The GPG Monitoring and Evaluation Plan has been developed.

The key challenges over the strategic plan period

The major challenges are strengthening our response to the three phases of the epidemic and our capacity to implement programmes in government, CBOs and NGOs.

1.Strengthen Our Response To The Epidemic

- Intensify Our Prevention Efforts
- Strengthen AIDS Care Capacity
- Mitigate the Socio-Economic Impact of AIDS on Families and Society

2. *Strengthen Our Capacity to Implement HIV/AIDS strategy*

- Increase Capacity To Manage Implementation In Government, CBOs and NGOs
- Maximise Co-Ordination And Communication

2.12. POLICIES, PRIORITIES and STRATEGIC OBJECTIVES

To implement an effective Inter-sectoral AIDS Strategy in Gauteng to reduce new HIV infections in youth and those at special risk, and reduce the impact of AIDS on People living with AIDS, their families and society. The Strategy will be implemented through all government departments and sectors, co-ordinated through a common strategy, plan and monitoring and evaluation systems. The capacity of all departments and sectors will be developed to contribute effectively.

THE GAUTENG INTER-SECTORAL AIDS STRATEGY

MOBILISATION & COMMUNICATION

To mobilise involvement and increase understanding. Reaches whole population through cultural activities, campaigns, role-models, leadership and media. Communicates progress with the programme. The content reflects the key areas of the programme: Openness, Prevention and Care; The Partnership against AIDS.

PREVENTION

EDUCATION- to change behaviour

Focussed on:

❑ Youth Strategy: Lifeskills in schools

Peer education for out of school youth and on campases.

❑ Peer education for special risk settings (mining, hostels, sex-workers, prisons)

❑ Workplace programmes (public & private sector)

SERVICES- in support of behaviour change

❑ STI management (syndromic management)

❑ Condom Supply (free male condoms)

❑ Voluntary testing with counselling (VCT)

❑ Reduce MTCT

❑PEP for sexual assault

CARE- "COMPREHENSIVE CARE"

SUPPORT OF PEOPLE WITH AIDS

❑ Community support (women, religious, civics, healers, etc)

❑ Support groups

❑ Counselling and VCT

CARE SERVICES

❑ Medical - clinics, hospitals, TB

❑ Palliative - Home Care and Hospice Beds

AFFECTED FAMILIES AND ORPHANS

❑ Social Support and donations

❑ Local orphan support projects

❑ Grants and services

❑Access to free services: housing, water, electricity, schooling, health services.

SYSTEMS FOR CO-ORDINATION AND REFERRAL

ORGANISATON OF THE AIDS PROGRAMME(all departments and sectors)

MUNICIPAL	PROVINCIAL
❑Mobilisation of communities	❑ Leadership ❑ Co-ordination ❑ Capacity Building
❑Co-ordinated plans	❑ Strategy ❑Provincial Plan ❑ Policy ❑ Guidelines
❑ Monitoring of Services	❑ Research ❑ Development ❑ Monitoring and evaluation
❑ Situation analysis and data base of services	

Notes

1. The strategy is consistent with the National AIDS Strategy.
2. The Gauteng AIDS Strategy has been revised to incorporate the recommendations of The Review Team. The orphan support strategy requires completion within 2002. The strategy will be revised based on further research and experience.
3. Several sub-programmes link care and prevention:
   ❑ Campaign against discrimination ❑Voluntary Counselling and Testing (VCT).

POLICIES

	STRATEGY/POLICIY	STATUS
1.	National AIDS Policy	National Policy
2.	Gauteng AIDS Strategy	Consistent with National. Reviewed by experts, endorsed by AIDS Summit
3.	TB Policies and targets	National Policy (Health)
4.	AIDS Media Strategy	Gauteng Programme
5.	Lifeskills /schools policy	National Policy: (Education)
6.	Peer Education	Gauteng AIDS Programme
7.	Workplace AIDS Strategy	Gauteng Government
8.	Health Services for Prevention STI Condoms VCT PMTCT PEP	 National Standards (Health) National Standards (Health) National Standards, provincial targets National Protocol, Gauteng plan National Protocol, Gauteng plan
9.	Medical care for HIV/AIDS	National guidelines (Health) Provincial guidelines (for public sector)
10.	Home-based care	National policy for Health and Social Services with provincial guidelines and plans
11.	Orphan support programme	National policy for Health and Social Services with provincial guidelines and plans
12	Hospice Beds	Provincial Plan (Health)
13	Local AIDS Programmes	Provincial Guidelines

NOTE: The Gauteng AIDS Programme reports to the Premier through the HOD and MEC for Health. Key provincial AIDS policies are adopted by the Provincial Executive Council. Departments are responsible for department specific policies and guidelines, consistent with departmental strategy.

Broad strategic goals

1.Reduce new HIV infections with special emphasis on youth (10 to 30 yrs), babies, special risk groups

2. Reduce the impact of aids on families and society
3. Organise the aids response through a decentralized inter-sectoral programme,

GOAL 1: REDUCE NEW HIV INFECTIONS in youth (10 to 30 yrs), babies and special risk groups.

BROAD STRATEGIC OBJECTIVES (3 YEAR)

- Improve understanding of HIV risk, transmission and prevention amongst youth and the public.
- Reduce risk behaviour through implementing effective educational programmes for specific groups:
- Provide accessible, effective services on large scale in support of prevention

-

GOAL 2: REDUCE THE IMPACT OF AIDS ON FAMILIES AND SOCIETY

BROAD STRATEGIC OBJECTIVES (3 YEAR)

- Increase openness and reduce discrimination around AIDS
- Provide access to comprehensive TB/HIV/AIDS care in 100% of local areas, including the PHC package of care and local referrals.
- Strengthen health systems management in order to improve service delivery on TB/HIV/AIDS care.
- Research the feasibility of adding ARV treatment to the PHC package of care.
- Extend access to comprehensive orphan support services to 100% of local areas.
- Increase access to socio-economic interventions for poor families to reduce the impact of AIDS.
- Establish an effective monitoring and evaluation system for care.

GOAL 3: ORGANISE THE AIDS RESPONSE

BROAD STRATEGIC OBJECTIVES (3 YEAR)

- Organise all departments and sectors in a joint effort on AIDS based on an effective AIDS Strategy and Plan
- Monitor and evaluate implementation of the AIDS Strategy
- Strengthen capacity of 20 departments and 15 sectors to deliver on the AIDS Strategy
- Establish Local Inter-Sectoral AIDS Programmes, co-ordinated by Municipalities.

Priorities for 2003/4

- Continue the social mobilisation and communication campaign
- Reduce the incidence of STD's
- Strengthen TB control programme
- Intensify prevention efforts to ensure a reduction in new HIV infection rates, especially in youth under 20 years of age and babies. (PMTCT)

- Implementation of workplace HIV/AIDS programme
- Developing comprehensive care and support for PWA's, care givers and affected children.
- Strengthening HIV/AIDS programme organization i.e ensure effective monitoring and evaluation system, establish Local inter-sectoral programmes develop and sustain capacity of departments and sectors

2.2 3. ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Management of implementation is the key challenge to effective implementation to scale. Key barriers can be described as:
"**Business as usual"** and "**battling with basics".**
'Business as usual' reflects gaps in leadership where line management fails to integrate AIDS effectively into Departmental Strategy, plans and budgets. There is a tendency to dodge responsibility and divert responsibility to AIDS support staff. The discrimination stigma and denial around AIDS contributes to this response. Many managers lack the level of insight and expertise required to translate the AIDS Strategy into effective implementation.
'Battling with basics' refers to the day-to-day difficulties faced by AIDS project managers. This includes:

- Appointing, developing and retaining skilled staff.

- Restructuring is the key factor in diluting AIDS expertise in Education, Health and Local Government. Staff turnover dents the development of much-needed capacity. Gaps in \ management support, contribute to frustration.
- Electronic infrastructure: defects in hard-ware, soft-ware, services and service-providers.

- The details of project and financial management: developing, approving and accessing plans and budgets, procurement procedures, tenders, the BAS system.

- The system for funding NGOs requires greater skills, experience and administrative support.
- Inadequate routine information systems make it difficult to monitor delivery, or contribute to effective management decision-making. This includes the lack of reporting on progress from both departments and NGOs.

- Crisis management and work overload. This affects capacity to consolidate existing programmes to ensure sustainability.

Condom and media supplies keep coming but require special effort to maintain. The supply of medicines and laboratory services are meeting the main service requirements for the Health Department.
A range of sub-programmes are implemented by Local NGOs. Most of these NGOs are new and have to set up governance and management structures and learn project management skills. Some training and support is provided but does not meet all the current needs.

Developing expertise is key to supporting the rapid development of a new programme.
Staff has developed expertise through experience but this is diluted by re-structuring and staff turnover. We need to develop skills on large-scale across government and other sectors. While training has been commissioned we experience some problems:

- Attendance at training courses is a problem.
- AIDS is not fully integrated into existing training programmes (undergraduate and in-service training).
- Limited AIDS expertise amongst training service providers.
- On the job support is needed to consolidate skills.

Local academic institutions have not kept up with the needs of the programme. Researchers and donors drive most research in the province. It is often not linked to programme development needs. Our access to international-level technical expertise does not meet all our needs and is not facilitated nationally.

Monitoring systems are deficient. Routine information systems are inadequate in Departments and in support of NGO services. Inadequate person-power is allocated to develop the systems needed. We are still relying on special surveys to monitor AIDS impact and programme service delivery.

The broad programme **Evaluation system** is being set up, based on UNAIDS guidelines. Evaluation of sub-programmes is behind schedule. Documentation and evaluation skills are not fully developed. It is therefore unclear at this stage what impact the prevention component is achieving. Measuring the impact of AIDS Care interventions is notoriously difficult.

Communication needs strengthening both internally and externally. Service providers are not fully informed of strategy, policy-guidelines and progress with delivery. This dents confidence, especially in the face of a critical external media. While advertising and publicity reaches millions of people, media liason needs special attention to communicate the government programme in the present context.

While **co-ordination** mechanisms have been set up, it is a challenging area requiring ongoing attention. Local Government capacity to co-ordinate the Local Inter-sectoral AIDS programme needs to be created in most areas. Some Local Government leadership has misinterpreted the role of co-ordination as taking over all decision-making.
The gap in programme management between national and province continues to create problems.

The **social context** in Gauteng continues to be a major external factor driving the epidemic including:
Poverty, migrancy and unemployment.
Breakdown in family structure and social values. Anti-social sub-cultures.
Crime and sexual violence.
The AIDS epidemic itself is now contributing to the cycle of social problems.

2.2.4. Description of planned quality improvement measures:

COMMUNITY LEVEL INTERVENTIONS:

Stigma and discrimination against HIV/AIDS remain the most disenabling problems at community level. It affects the uptake of programmes and compliance with interventions for prevention and care significantly negatively. PWA support groups, mass community education and mobilisation, use of PWA's as models are some of the strategies to deal with this problem. It is important to ensure implementation of the comprehensive care approach at community level to address issues of family disruption, orphan care and support, etc through the local inter-sectoral programmes. The IDU unit has part of the plan to deal with this problem. There is a plan also involve the Health Promotion more effectively in public education on AIDS prevention, care and support.

PRIMARY HEALTH CARE:

Strengthening primary health care is central to addressing the impact of HIV/AIDS /TB on the health sector. The ten point plan, the strategic position statement, the provincial health for a better life strategic plan, the Gauteng inter-sectoral AIDS strategy, the CHP study and the strategic and operational plans of the public health directorate all guide the activities to ensure that all clinics in the province provide a package of good quality care to people with HIV/AIDS by March 2004. Key services (primary HIV/AIDS care according to guidelines, counselling and testing, STI, and TB services) should be provided by 100% of clinics by 2004, and comprehensive care by 2005. Training of primary health care service providers will ensure that they have adequate clinical skills to manage HIV/AIDS including palliative care in clinics. Training will be on basic science and the management protocols. Work in pre service and in service in this regard has already commenced. This is done by the HIV/AIDS unit and human resource development directorate.
It is imperative to ensure integration of these services into the primary health care system but specifically into TB/FP/PMTCT/STI programmes initially. Capacity for HIV counselling is to be increased both from the perspective of VCT and as part of Comprehensive care ongoing counselling. Currently only 20% of the clinics have in-house lay counsellors. This is being addressed and the target is to have all clinics with this service by 2004. Drugs to treat opportunistic infections and palliative care have to available at clinics. The EDL needs to be expanded to include drugs that are not currently covered. A level specific facility checklist will be developed to assist clinic managers in ensuring provision of good quality care. Referral networks will be improved using area-based planning which should reflect the comprehensive care delivery system in an area. Networks and effective referral systems up and down levels of care including other sectors and the local NGO's and CBO's will form part of area based planning. Support systems to address issues of service provider morale and motivation need to be enhanced. Monitoring workloads and staff equity, defining roles of clinic managers, monitoring stress and burnout amongst providers and dealing with through the EAP's will be continued to ensure high morale and motivation. HIV/AIDS specific indicators for the clinic minimum data set are being finalised for integration. Introduction of ARV's at this level will be investigated. All of these require good cooperation between authorities at provincial, regional, district, and local level.

HOSPITALS BY LEVEL:

The ten point plan, the strategic position statement, the provincial strategic plan, the Gauteng AIDS inter-sectoral strategy, and unit operational plans guide activities to improve health services and to manage and reduce the impact of HIV/AIDS on the health sector. Separating level 1 beds from level 3 hospitals will ensure appropriate utilisation of resources.The impact study done by Abt Associates gives some indications in terms of projected acute adult and paediatric bed day requirements. (There may be other studies). Guidelines defining packages of care at different levels will be provided for area based planning. Funds are available for step down beds. Hospitals are currently not utilising HBC referral system effectively, this is being addressed. Hospital MOPD and specialist HIV/AIDS clinics for difficult cases need to be identified. These are currently placed at tertiary level institutions but not necessarily clearly described in area based plans. In patient stay to meet recommended targets has to be managed. Introduction of ARV's and the role of hospitals is to be investigated. There is compelling evidence on the cost effectiveness of this intervention.

Referral systems will be defined by area-based plans and mapping of services .The target is to have 80% of hospitals implementing provincial protocols by 2004. Professionals are currently being introduced to the protocols. Protocols will be reviewed as need arises. A tender will be sought for a consultant to conduct hospital impact studies in 2003. A sentinel surveillance system will be set up in 2003 to be implemented by 2004. HIV/AIDS will be part of the hospital MDS within acceptable ethical standards. The EAP and HIV/AIDS workplace programmes will be enforced to deal with personnel related issues.

PROGRAMME MANAGEMENT:

There is need to improve the skills of managers and service providers in project management and financial management. Additional training is also needed with regard on compiling business plans and report writing.

5. SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS: Health Department)

Strategic objectives	Measurable objectives	Indicator	2001/2 (actual)	2002/3 (estimate)	20003/4 (target)	2004/5 (target)	2005/6 (target)
Strengthening the Tuberculosis control programme	Cure 85% of new TB cases at first attempt	Smear positive TB cases as percentage of all PTB cases.	79%	75%	80%	80%	80%
		New smear positive PTB cases as percentage of expected number of cases.	69%	70%	70%	70%	70%
		Percentage of new smear positive cases cured at the first attempt.	68%	68%	70%	75%	80%
		Number of health districts using DOTS	6	6	6	6	6
		Percentage of TB cases with a DOT supporter.	94%	95%	96%	98%	100%

		Number of TB/HIV health districts					
		Percentage of TB cases reported on.	95	97	98	100	100
		Average TB specimen turn around time in <48 hours	61	64	70	75	80
		Percentage of TB cases who are being retreated.	15	15	15	15	15
		PTB smear conversion rate at 2 months for new cases.	68	60	70	75	85
		PTB smear conversion rates at 3 months for re-treated cases.	50	50	60	70	80
		Percentage of TB bases that are MDR.	1	2	2	2	2

	Reduce the interruption rate to <10% by 2005	Percentage of new smear positive cases that interrupt treatment	13	12	10	8	5
Reduce the incidence of STD's & new HIV infections and the impact of AIDS	Reduce the incidence of STI's	Incidence of male urethral discharges	57.5	61.0	50	48	45
	Provide appropriate diagnosis, treatment and counselling of patients with STI's in health facilities	Percentage of facilities of all types offering syndromic management of STI's.	90	90	95	100	100
		Number of people trained in syndromic management of STI's.	521	700	2000	3000	5000
	Limit the rate of increase in HIV prevalence among women attending antenatal care.	HIV prevalence for under 20 years	19.4		18%	15%	12%
	Improve accessibility of male and female condoms	Proportion of PHC facilities where condoms are freely available	90%	95%	99%	100%	100%
		Number of female condoms distributed	100 000	100 000	120 000	130 000	140 000
		Number of male condoms distributed	7 million per month	7 million per month	7 million per month	7 million per month	7 million per month

	Increase access to voluntary counselling and testing	Percentage of provincial hospitals and clinics offering VCT	15%	30%	60%	80%	90%
	Prevent mother to child transmission (PMTCT)	Percentage hospitals and large community health centres that implement the programme	100% hosp. 75% CHC's	100	100	100	100
		Total dedicated expenditure on HIV/AIDS activities.	Data still being verified				

Table: Measurable objectives and performance indicators for the Inte Sectoral Strategy

SUB-PGM	*OBJECTIVE (3YRS)*	*INDICATORS*	*BASELINE*	*1*	*3YR*	*BUDGET*	*DEPT*
COMMUNICATION	Improve understanding of prevention and care amongst youth and the public	Youth knowledge of HIV-prevention Willing to care for on BSS	80% (from MR)	85%	90%	9,000	IDU
	Campaigns reach 80% of public	Campaign reach millions p.a	6 mil	7 mil	8 mil	4,000	GDH IDU
MOBILISATION	Participation of all sectors Defn: Campaigns, pgms	Number of sectors involved in campaigns and pgm	7	9	10	R3,500	IDU
	Joint Strategy and Plans (4 x per year)	Depts +sectors involved in planning + forms	60%	80%	100%	See Programme Mgmt	
PREVENTION							
PREVENTION EDUCATION Education, services	Lifeskills pgm in schools Defn of: Pgm indicators (see survey).	% of schools implementing (Annual survey)	80%	85%	100%	R14,500 NCG to GDE	GDE
	Special risk pgm: mining, inner-city, hostels, prisons, taxis	% of key areas with pgms	80%	90%	100%	R4,500	4 Depts
	GPG Workplace pgm implemented per Strategy	Nos of depts. Implementing pgm BSS survey	6 -	8 1	10 1	R6,2 See M+E	5 Depts IDU

PREVENTION SERVICES (HEALTH DEPT) (drafts to be checked)	**- STI pgm** 100% of clinics syndromic mgmt	% clinics	85%	90%	100%	See medical care	GDH
	CONDOM SUPPLY - Supply free male condoms (with info system - Supply free female condoms (targeted) - Supply thru all PHC facilities	mil p.m. 100,000 % facilities	7 ? 90	7 ? 95	9 ? 100%	R1,500: National supplies condoms	GDH
	VCT - Test 10% of population (15-49 yr) - Increase access to VCT service	% pop tested (age group) % PHC clinics provide VCT service % of sub-district with dedicated VCT services	1% 85% ? 60%	3% p.a. ? 90%	5% p.a. 100% 100%	(R8,060) NCG To GDH	GDH
	PMTCT - Reduce HIV transmission - Increase access to PMTCT service	% of infected babies % hospital % fixed PHC	100% ? 60%	100% 80%	100% 100%	R8,000: (R7,999) NCG to GDH	GDH

HEALTH DEPT (draft)	**PEP:** Include ARV prophylaxis in service for sexual assault	% services implemented 1. Crisis clinic 2. Hospitals	 90% ?	 100% ?	 100% ?	R8,000 Also from GDH	GDH
CA R E							
COMMUNITY SUPPORT	Community support for PWAs	1. % people prepared to care for PWA on BSS 2. % Local areas with PWA support group.	? 50% ? 60%	70% 80%	90% 100%	 R3,500	 GDH

HEALTH CARE **(HEALTH DEPT) DRAFTS**	Provide PHC package of care for TB/HIV/AIDS: 1. TB 2. HIV/care 3. Palliative 4. AIDS care Defn: See guidelines	% of Sub-districts % of fixed clinics △ + Rx △ + Rx % of CHCs % of CHC	? 80% ? 90% 90% ? ?	95% ? 95% 90% ? 100%	100% ? 100% 100% 100% 100%	R2,000	GDH
	Implement the DOTS strategy/TBCP policy 1. DOTS 2. TB Register details	 No of TB pts % Districts with DOTS % smear + re % etc.	To add - - - -	To add	To add	See TB budget	GDH
	Implement clinical guidelines in all hospitals with training and M+E	% clinicians trained	? %	?	?		
	Provide HBC service in all sub-districts .	sub-district with HBC services	? 90%	90%	100%	R10,000: (R9,443): NCG to GDH	GDH
	Provide step-down/ Hospice beds	Number of beds	200	345	400	NCG to GDH GDH GDH (R7,000) +NCG	GDH
	Referral system with database in each sub-district:	Database % areas System	?	90%	100%	GDH	

	Research addition of ARV treatment to the PHC package.	Feasibility study Treatment plan	- -	1 1	- -	Global Fund	GDH
SOCIAL SUPPORT							
1. CHILDRENS SERVICES	- Provide social worker services - Extend local orphan support services to CBC in local areas	% of local areas with access to services Nos of CBCs With orphan support services	? 40% 35%	60% ?	100% ?	Dept budget SS budget R10,000: (R9,443): NCG to SS	Social Services
2. ACCESS SOCIAL RELIEF	- Promote access to indigent families for free services	Policies in place Research of feasibility	3 -	4 1	5 -	Other sources	IDU + Social Services

ORGANISATION							
PGM ORGANISATION	Implement the Gauteng AIDS Strategy effectively: - Leadership: PCA GAC, - Co-ordination: - Communication	Revised Strategy Plan + budget Meetings per year Fora reports p.a. Newsletter pa Database pa Documentation Communication focus	1 1 4 4 1 p.a. 4 p.a. 4 p.a.	1 1 4 4 1 p.a. 4 p.a. 4 p.a.	1 1 4 4 1 p.a. 4 pa 4 pa	R9,060	IDU
	- M+E system - Evaluate dept pgms - Routine reporting systems	Surveys yearly - ANC - BSS (x 2) Survey/research per dept per year Annual report % Dept Quarterly: to HODs + IDU Routine info system per Dept on indicators	p.a p.a. 80% 1 ? 30% < 30%	p.a. p.a. 100% 1 100% 60%	p.a. p.a. 100% 1 100% 100%	R4,500	IDU

	- Research Fora - Financial mgmt capacity	Research fora % mgrs trained monthly fin reports % budget spent	4 < 50% < 50% >90%	4 70% 80% 100%	4 95% 100% 100%	R1,500	IDU
LOCAL PROGRAMMES	Strengthen local programme:	Local AIDS pgm in 6 municipal areas	?	6	6	R4,000 (Municipalities)	DPLG

SUB PROGRAMME 2.3: NUTRITION

2.3.1 SITUATION ANALYSIS

Nutritional status is one of the major determinants of normal physical and mental growth. The National Food Consumption Survey (NFCS) of 1999 showed that at least 20.4% of children in Gauteng between the ages of

1-9 yrs are stunted (low height for age). Children between the ages of 1-3 years old were the most severely affected – Gauteng: 26.2%; RSA: 25,5%. It also found that 8.8% of children in the 1-9 age group were underweight for age (RSA: 10.3%). Wasting (low for height) was found to be not so common in Gauteng (Gauteng: 1.2%; RSA: 3.7%).

In addition to chronic exposure to low energy intakes (stunting) and acute under nutrition (underweight), micronutrient deficiencies substantially affect the nutritional status, health and development of the population. Gauteng also has high low birth weight prevalence with an estimated 18.4% of babies born with weights below 2.5kg (1999). This is an indication of the maternal health status and socio-economic situation of the community. The South African Demographic and Health Survey (SADHS) of 1998 also highlighted that the prevalence rate of exclusive breastfeeding is very low.

The nutritional status of the children of Gauteng and South Africa has deteriorated when the findings of the NFCS are compared to the South African Vitamin A Consultative Group (SAVACG) study that was done in 1995.

The National Food Consumption Survey (2000) studies show that Vitamin A consumption on average is about 15% for children less than 10 years.

Table: Baseline Nutrition Indicators

Indicator	Provincial Status	Data Source
Child stunting	20.4 %	National Food Consumption Survey 1999
Child wasting	1.2%	National Food Consumption Survey 1999
Child underweight	8.8%	National Food Consumption Survey 1999
Child severe underweight		National Food Consumption Survey 1999
1.1 Adult overweight	29% men 56% women - RSA	South African Demographic and Health Survey 1998
1.2 Adult obesity	9.1% men 29.4% women -RSA	South African Demographic and Health Survey 1998
Child vitamin A deficiency	11%	South African Vitamin A Consultative Group Survey 1995
1.3 Child iron deficiency		South African Vitamin A Consultative Group Survey 1995
Iodine deficiency disorders	10.6% of the schools surveyed	National Iodine Deficiency Disorder Survey 1998
Exclusive breast feeding	1.4 10.4% (0-3months) 7.0 % (0-5months) - RSA	South African Demographic and Health Survey 1998
Continued breast feeding		South African Demographic and Health Survey 1998

Table: Performance indicators for the integrated nutrition programme

Indicator	Province wide value	By health district	National target by 2005
Input (children 0 – 72 months)			
1. Percentage of nutrition posts filled at all levels against nutrition staff establishment	Data still being verified		100%
Process			
2. Provincial business plan submitted and approved by national department by 15 March each year	100%		
3. Provincial monthly financial reports in terms Division Revenue Act. submitted to national department by 15th working day of following month	100%		
4. Provincial quarterly progress reports submitted to national department by 10th working day of following quarter	50%		
Output			
5. Percentage of targeted primary schools with feeding programmes against total targeted primary schools	85%		96%
6. Number of actual school feeding days as percentage of target number of school feeding days,	106% (166 days)		156 days
Quality			
7. Percentage of facilities with maternity beds certified as baby friendly against total facilities with maternity beds	1 facility		15%
8. Percentage of targeted schools where actual servings for school feeding comply with requirements and specifications of the standardised menu options	95%		100%
Efficiency			
9. Percentage of INP conditional grants spent	Data still being verified		100%
10. Percentage of special allocation for poverty relief spent	82%		80%
Outcome			
11. Average percentage of children under 5 years of age monitored for nutrition status in district health facilities showing faltering or failure of weight gain	Data still being collected		
12. Average percentage of children under five of age monitored for nutrition status in district health facilities diagnosed as suffering from severe malnutrition	Data still being collected		

2.3.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

Policies

- The integrated Nutrition programme is implemented within the umbrella of the following policies and guidelines

- Section 28 (c) of the constitution "Every child has the right to basic nutrition"

Guidelines

- Guidelines on the management of severe malnutrition
  -Therapeutic Protocols on the management of chronic illnesses
- Training modules on GMP
- Guidelines on Supplementary Feeding Scheme (SFS)
- South African Breastfeeding Guidelines for Health Workers

- A Health Workers Guide to the International Code of Marketing of Breastmilk Substitutes

- The South African National Guidelines on Nutrition People living with TB, HIV/AIDS and Other Chronic Debilitating Conditions

- Guidelines on Primary School Feeding Scheme

- National Vitamin A supplementation Guidelines and

- National iodine Deficiency Guidelines, Road to Health Chart

  (RtHC)

Broad strategic objectives

- The main priority of the Department is to improve the nutritional status of vulnerable groups through
  - Reduction of malnutrition for children under 5 years
  - Growth monitoring and promotion (GMP)
  - Reduction and control of micronutrient deficiencies
  - Health education and advocacy
  - Establishment of successful and sustainable income generating projects
  - Promotion of optimal growth of infants and young children
  - Food Service Management for provision of balanced nutrition to groups in the community and in public institutions.
  - Promotion, protection and support for breast feeding
- Contribution to household food security including school feeding and community poverty relief projects.

  -

2.3.4 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

- **Human Resources**

  Lack of sufficient skilled personnel to oversee effective and efficient implementation of Nutrition policies and programmes.

- **Finance**

  - The level of knowledge and skills regarding finance management and administration needs to be improved, considering the huge amounts being managed under this programme.
  - A finance expert is required, dedicated to the nutrition programme.

- **Information**

  There is a lack of reliable information on the current status. Information.

2.3.4 DESCRIPTION OF PLANNED QUALITY IMPROVEMENT MEASURES

One of the key measures to improve our interventions will be through integrated planning with other programmes through

- Strengthening the nutritional management and growth monitoring & promotion in the IMCI. Including other measures such as immunization and breastfeeding promotion.
- Incorporate nutrition in the AIDS/HIV and TB programme
- In achieving more mother baby friendly maternity facilities.
- In promoting and supporting breastfeeding.
- Contribution to household food security
- Food Service management: Outsourcing of the catering services in public institutions needs to be re-visited, in ensuring efficiency, cost effectiveness and that quality meals are served at all times for clients.
- Nutrition promotion, education and advocacy: developing information material and creating awareness on nutrition in general.

2.3.5 PRESENTATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table: measurable objectives and performance indicators for Integrated Nutrition Programme

Strategic Objectives	Measurable Objective	Indicator	2001/02 (actual)	2002/03 (estimate)	2003/04 (target)	2004/05 (target)	2005/06 (target)
Improve nutritional status of vulnerable groups	To increase regular growth monitoring (GMP) of children under 5 yrs of age	% of children <5 yrs of age monitored for growth % of newborn babies with RtHC	130 000	132 000	134 000	135 000	136 000
	To establish successful and sustainable income generation projects.	Number of sustainable projects.	14	19	19	25	28
	To prevent, reduce and control micronutrient deficiencies in children.	% of children with micronutrient deficiencies	#	20 000	19 200	18 750	18 000
	Increase the number of maternity facilities that are mother-baby friendly	Percentage of maternity facilities certified as baby-friendly	1 *(number)* Data is still being verified	1 *(number)*	3 *(number)*	5 *(number)*	8

	Alleviate temporary hunger in needy primary school children	Percentage targeted schools with feeding programmes	75	77	80	100	100
		Percentage of targeted schools where actual servings for school feeding comply with requirements and specifications of the standardised menu options	73	74	77	80	85
		Percentage of INP conditional grants spent	85	100	100	100	100
		Percentage of special allocation for poverty relief spent	82	83	90	90	100

New indicator, data not available

SUB PROGRAMME 2.4: DISTRICT HOSPITAL SERVICES

2.4.1 SITUATION ANALYSIS

Situational analysis will be provided with the final strategic plan

Table: Performance indicators for District Hospital services

Indicator	Province wide value 2001/02	Hospital range	National target
Input			
1. Expenditure on hospital staff as percentage of total hospital expenditure	✓	✓	
2. Expenditure on drugs for hospital use as percentage of total hospital expenditure	✓	✓	
3. Expenditure on hospital maintenance as percentage of total hospital expenditure	✓	✓	
4. Useable beds per 1000 people*	0,1		
5. Useable beds per 1000 uninsured people*	0,2		
6. Hospital expenditure per person*	R 45,2		
7. Hospital expenditure per uninsured person*	R 61,2		
Process			
8. Percentage of hospitals with operational hospital board	✓		
9. Percentage of hospitals with appointed (not acting) CEO in place	✓		
10. Percentage of hospitals with business plan agreed with provincial health department	✓		
11. Percentage of hospitals with up to date asset register	✓		
12. Maximum permitted value of procurement at discretion of hospital CEO without reference to provincial level	✓	✓	
Output			
13. Separations per 1000 people*	✓		
14. Separations per 1000 uninsured people*	✓		
15. Patient day equivalents per 1000 people*	44,5		
16. Patient day equivalents per 1000 uninsured people*	60,3		
17. Patient fee income per separation	✓	✓	
Quality			
18. Percentage of hospitals in facility audit condition 4 or 5	✓		
19. Percentage of hospitals that have conducted and published a patient satisfaction survey in last 12 months	✓		
20. Percentage of hospitals with designated official responsible for coordinating quality management	✓		
21. Percentage of hospitals with clinical audit (M&M) meetings at least once a month	✓		
Efficiency			
22. Average length of stay	3,1	✓	
23. Bed utilisation rate (based on useable beds)	69,6	✓	
24. Expenditure per patient day equivalent	R 1016	✓	
Outcome			
25. Case fatality rate for surgery separations	✓	✓	

✓ *Data still being collected or verified*

2.4.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

Broad strategic objectives

- Ensure reduction in the average day cost
- Increase the proportion of patients attended in ambulatory care (PHC level)
- Provide efficient and effective clinical support services

2,4,3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Analysis will be provided with the final strategic plan.

2.4.4 DESCRIPTION OF PLANNED QUALITY IMPROVEMENT MEASURES

Description will be provided with the final strategic plan.

2.4.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table: Measurable objectives and evolution of performance indicators for District hospitals

Strategic Objectives	Measurable Objective	Indicator[1]	2001/02 (actual)[2]	2002/03 (estimate)[2]	2003/04 (target)	2004/05 (target)	2005/06 (target)
Strengthen community participation and maintenance of infrastructure and equipment	Establish hospital boards in the hospitals	Percentage hospitals with operational hospital board established	100	100	100	100	100
Revitalisation of hospital services	Develop a business for the hospital *(Service plan)*	Percentage of hospitals with business plan agreed with provincial health department	#	#	33	50	100
Improve financial management	Ensure delegated functions to CEO of the hospitals	Maximum permitted value of procurement at discretion of hospital CEO without reference to provincial level	#	#	Data still being verified		
Improve quality of care	Conduct and publish patient satisfaction survey annually	Percentage of hospitals conducted and published patient satisfaction survey in the last 12 month	#	#	100	100	100
	Ensure coordination of quality management in hospitals	Percentage of hospitals with designated official responsible for coordinating quality management	Data still being verified				

	Establish clinical audit in all hospitals	Percentage of hospitals with clinical audit (M&M meetings at least once a month	#	#	50	100	100
	Improve hospital utilisation	Number beds Usable beds per 1000 people Useable beds per 1000 uninsured	858	858	1257 Still to be determined	1650	2060
		Number of admissions	71123	71123	98696	123232	154040
		Admissions per 1000 uninsured	13.7	13.7	20	25	30
		Number of outpatient	329966	329966	40000	440000	480000
		Patient Day Equivalents (PDE's)	327821.7	327821.7	445070	511830	588600
		Patient day equivalent (PDE) per 1000 people Patient day equivalent (PDE) per 1000 uninsured people			Still to be determined		

		Separation per 1000 people Separation per 1000 uninsured people Case fatality rate for surgery separation					
Equitable distribution of resources	Ensure hospital efficiency	Expenditure on hospital staff as percentage of total hospital expenditure Expenditure on drugs for hospital use as percentage of total hospital expenditure Expenditure on hospital maintenance as percentage of total hospital expenditure Patient fee income per separation Hospital expenditure per person Hospital expenditure per uninsured person	Data still being verified		Still to be determined		

	Improve hospital efficiency	Average length of stay (ALOS)	34	3	3	3	3
		Bed Occupancy rate (BOR)	69.9	70	75	75	75
		Cost per PDE	R1016	R1016	R600	R500	R400

PROGRAMME 3: EMERGENCY MEDICAL SERVICES

3.1 SITUATIONAL ANALYSIS

Although the provision of emergency medical services is the competence of Provincial departments, in Gauteng local authorities provide the service on an agency basis. The history of this relationship has been problems such as lack of uniform service standard, lack of monitoring and inefficiencies in the system to mention but a few. In the last year Department has made the following major achievements to improve Emergency Medical Services in the province.

- The Ambulance Services Bill, 2002 has been passed by the Gauteng Legislature and the regulations will be published for comments during December 2002.
- All the Districts and Metro Councils who deliver the service have signed the revised Memorandum of Agreement based on Emergency Medical Services norms and standards.
- The EMS response on calls for critically ill or injured patient within 15 minutes was 92.3% *(urban)*. Annually, 100% trained ambulance personnel attend more than 411 255 incidents costing R555.89 per patient transported.
- There are a total of 287 ambulances traveling over 13 million kilometres per year with an average cost per kilometre of R18.56.
- In the 2001-2002 financial year there were 2305 staff members of who 778 were registered Basic Ambulance Assistants, 521 were Ambulance Emergency Assistants and 81 were paramedics (ie advanced life support trained).

Table: Performance indicators for emergency medical services*

Indicator	Province wide value	By health district	National target
Input			
Number of vehicles per 1000 people	47.8	*	
Process			
Number of vehicles replaced per year	24	*	
Output			
Total kilometres travelled per year	13 778 161	*	---
Number of patients transported per 1000 people per year	355 281	*	
Quality			
Percentage of call outs answered by single person crew	0	*	
Percentage of locally based staff with training in life support at basic level	46.56%	*	
Percentage of locally based staff with training in life support at intermediate level	46.1%	*	
Percentage of locally based staff with training in life support at advanced level	7.34%	*	
Efficiency			
Cost per patient transported	R555.89	*	
Outcome			

Proportion of P1 patients responded to within 15 minutes	92.3%	*	Urban area < 15 mins. Rural area < 40 mins

- Populations based on 1996 census.
- The symbol *means data still being verified.

Resource Allocation

The table below outlines the budget and vehicle allocation to the local authorities as determined by Norms and Standards. Emergency medical services received a budget of R197,5 million, which amounts to 80% of funding according to the Norms and Standards.

AGENT	TRANSFER BUDGET	AMBULANCE	RESPONSE VEHICLE	MINIBUS
Ekurhuleni Metropolitan Municipality	R 43,177,000.00	70 [68]	22 [14]	9
Metsweding District Municipality	R 7,161,000.00	9 [8]	3 [2]	2
City of Tshwane	R 20,195,000.00	24 [30]	10 [6]	3
City of Johannesburg	R 34,086,000.00	48 [53]	15 [11]	5
Sedibeng District Municipality	R 16,642,000.00	25 [24]	8 [5]	4
West Rand District Municipality	R 15,354,000.00	19 [22]	10 [4]	1

* The figures in [ ] reflect the full basic Norms and Standards quantity of vehicles.

In addition to the Transfer Budget, EMS also has a Central Budget of R 85 885 000, which is used to fund the vehicle fleet, medical equipment, and consumable medical supplies, communications infrastructure and specialised services, eg the transport of patients by air ambulance.

Key challenges over the strategic plan challenges

- Monitoring of the new memoranda of agreements in terms of the norms and standards
- Implementing and effective inter institutional transport system
- Establishment of an effective bed management bureau
- Restructuring of Emergency Medical Services sub-directorate (including the decentralization of services to regional and district level)
- Availability of Emergency Vehicles (due to the interdict on the tender for a new FML)

3.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

Policies

The following major policies are used as a basis for rendering emergency patient transport and planned patient transport:

- The constitution Section 27 (3) of the Constitution
- Gauteng Ambulance Services Bill, 2002
- Memorandum of Agreements with municipalities
- Emergency Medical Services (EMS) Norms and Standards

Broad Strategic Objectives

- Ensuring rapid and effective emergency services remains a major strategic priority of the Department.
- Ensure efficient emergency and planned patient transport
- Ensure decentralisation of Emergency Medical Services in the province in collaboration Districts and Metro Councils
- Implementation of the Gauteng Ambulance Services Bill, 2002
- Implementation of the Regulations in terms of the Ambulance Services Bill, 2002

Priorities

- Compliance with the 2001 Basic Norms and Standards by agents
    - Improve the monitoring of response times
    - Improve reporting and compliance with PFMA(financial reports, monitoring of indicators and outcomes)
    - Finalise the restructuring of EMS to improve capacity at central and regional offices
    - Increase ambulance personnel with in Advance Life Support training

3.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

EMS Basic Norms and Standards

The most critical constraint facing EMS is the delay in replacing the existing emergency vehicle fleet. Vehicles that are not available due to breakdowns are seriously hampering the ability of agents to achieve the set standards.

Although some vehicles were purchased, the need is growing daily and due to a limited budget, alternative methods of improving the existing fleet need to be investigated.

Budgetary constraints have always existed in EMS with the agents generally having to contribute towards the cost of running the service. The partial retention of revenue as specified by Treasury will assist in improving the funds available to the service and create incentives to improve the collection of revenue.

Reports from Districts and Metro Councils

The submission of accurate and timely reports by agents is still not ideal. This impacts on the accurate evaluation of indicators. Therefore there is a need to improve the flow of information between the Department and the Districts and Metro Councils.

Restructure the EMS head office component

Serious delays have occurred in appointing staff in the regional EMS units, which has placed additional strain on the Central Office component. The National moratorium on the filling of posts has added to the delays experienced. A proposal to fill the vacant posts as critical posts has been submitted for consideration by top management.

Availability of Emergency Vehicles

A delay in implementing a new Full Maintenance Lease tender to replace the existing emergency vehicles is placing a strain on the service. The existing fleet is not in an optimal condition and breakdown of vehicles occur on a daily basis and at enormous costs to the Department. The average downtime of vehicles vary from 25 – 30% however some services may experience downtimes in excess of 60%. The purchase of 24 new ambulances and an additional 20 in the financial year 2002/3 is an attempt to improve the situation.

3.4 DESCRIPTION OF PLANNED QUALITY IMPROVEMENT MEASURES

The following projects are at present underway to improve the quality of the service provided:

- A new patient report form has been developed and the first consignment of books are underway to improve transfer of information to other healthcare workers and easier review of cases when needed.
- Linen is being purchased to allow for a more professional appearance of the service and ensure improved comfort and dignity of patients.
- Policies on Medical Waste Management and protection against infective agents for staff and patients are presently being reviewed.

- Decentralisation of the operational component of EMS Head Office will allow more capacity to do inspections and ensure compliance to set standards.

3.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table: Measurable objectives and performance indicators for Emergency Medical Services

Strategic Objectives	Measurable Objective	Indicator[1]	2001/02 (actual)[2]	2002/03 (estimate)[2]	2003/04 (target)	2004/05 (target)	2005/06 (target)
Ensure rapid and effective emergency care	Ensure rapid response to priority one patient (critically ill or injured patients)	Percentage of priority one patients responded to within 15 minutes	92.3	82.56	85	90	92
		Percentage of all patients responded to within 15 minutes	#	70	80	80	80
	Improve access to emergency medical services.	Number of vehicles	287	287	191	271	Maintain
		Number of vehicles replaced per year	24	20	100	80	Maintain
		Number of vehicles per 1000 people	0.038	0.038	0.025	0.036	
		Total kilometers traveled	13 778 161	14 000 000	14 500 000	15 000 000	15 000 000
		Number of patient transported per year	355 281	400 000	450 000	500 000	550 000
	Ensure efficient Emergency Medical Service	Cost per Kilometer traveled	RR14.38	R15.59	R18.56	R18.85	R19.55
		Cost per patient transported	RR555.89	R550	R600	R600	R600

Ensure rapid and effective emergency care	Implement Emergency Medical Services norms and standards	Percentage of operational vehicles relative to Norms And Standards	80 %	80%	80%	100%	100%
	Improve access to information on available hospital beds to clinicians	Percentage of beds monitored on a real time basis	#	5	20	80	90

*New indicator, data not available*

3.6 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Table: Evolution of expenditure by budget programme and sub-programme in current prices (R million)[1]

Sub-programme	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)	2004'05 (MTEF projection)	2005/06 (MTEF projection)
1. Emergency transport	165,053	206,787	222,500	253,260	269,948	283,945
2. Planned patient transport				50	52	55
Total programme	165,053	206,787	222,500	253,310	270,000	284,000

Table: Evolution of expenditure of budget programme in constant 2002/03 prices (R million)[1]

Expenditure	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	Average annual change (%)	2003/04 (budget)[2]
Total[3]	165,053	206,787	222,500		253,310
Total per person[4]	22.40	28.07	30.20	0.00	34.38
Total per uninsured person[5]	30.35	38.03	40.92	0.00	46.58

PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES

4.1 SITUATION ANALYSIS

Gauteng has 13 regional hospitals, 3 Academic dental hospitals, 4 psychiatric hospitals, 1 infectious diseases hospitals, contracted TB and psychiatric beds (4995) with a total of 14349 beds providing general and specialized hospital services, chronic mental and tuberculosis in-patient care on agency basis for the Department and oral health services and a platform of training of health workers.

NB: The detailed physical conditions of hospital network has been done and presented as part of Programme 8: Health facility management

4.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

The strategic position statement (SPS) forms the basis for development provincial hospital services strategic plan whilst observing the principles of equity, access, efficiency, quality and community involvement. A shift from hospitals to primary health care and ambulatory care is anticipated by the model option and requires a shift of resource allocation to achieve this end. Key to this process is a methodology of measuring and monitoring the drivers of costs through population, admissions, hospital length of stay, level of care and costs and HIV/AIDS.

Broad Objectives

- Strengthening of regional hospitals
- Ensure a shift to Primary Health Care and district-level care
- Relocation of hospital beds from well-served areas to underserved areas
- Ensure that a higher proportion of patients are seen at lower level
- Provide efficient and effective clinical support
- Provide high quality and user-friendly hotel facilities
- Improve quality of care
- Ensure equitable and efficient distribution and use of resources
- Reduce incidence and impact of trauma and violence

4.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Analysis will be provided with the final strategic plan.

4.4 DESCRIPTION OF PLANNED QUALITY IMPROVEMENT MEASURES

- Summary of description is presented in programme 1
- Detailed description will be provided with the final strategic plan

4.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table: Measurable objectives and evolution of performance indicators for provincial hospital services

Strategic Objectives	Measurable Objective	Indicator[1]	2001/02 (actual)[2]	2002/03 (estimate)[2]	2003/04 (target)	2004/05 (target)	2005/06 (target)
Revitalisation of hospital services	Strengthened and capacitated management team in hospitals	Percentage filled top management posts	90	95	100	100	100
Reduce incidence and impact of trauma and violence	Priority one patient (critically ill patients) attended to within 15 minutes in casualty departments	Percentage priority one patients attended to within 15 minutes in causalities	-	70	100	100	100
Improve quality of care	Shorter waiting times for patients	Percentage of hospitals measuring waiting times Percentage reduction in overall waiting times	Data still being collected #	#	100 10	100 15	100 20
Equitable distribution of resources	Hospital utilization	Number of beds Usable beds per 1000 people Useable beds per 1000 uninsured	9394 Data still being verified	9394	6368	6368	6368

		Number of admissions	Data still being verified		335798	319008	303057
		Admissions per 1000 uninsured			40	40	40
		Number of out patients			1048280	1048280	946072
		Patient day Equivalent (PDE's)			1965854	1867561	1774183
		Patient day equivalent (PDE) per 1000 people	Data still being verified		Still to be determined		
		Patient day equivalent (PDE) per 1000 uninsured people					
Equitable distribution of resources	Improved hospital efficiency	Average length of stay (ALOS)	4.3	4.4	4.5	4	4
		Bed Occupancy Rate (BOR)	Data still being verified		75	80	85
		Cost per PDE Expenditure on hospital staff as			R439.3*	R439.3*	R439.3*

1. Figure does not include Psychiatric/mental hospitals
* Estimates only
# New indicator, data not available

4.6 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Table: Evolution of expenditure by budget programme and sub-programme in current prices (R million)[1]

Sub-programme	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)	2004'05 (MTEF projection)	2005/06 (MTEF projection)
1. General hospitals	840,411	906,466	1,641,299	1,736,790	1,877,171	1,962,000
2. Psychiatric/mental hospitals	327,286	322,557	348,836	411,900	433,000	457,200
3. Other Specialised Hospitals	26,229	31836	37,824	43,100	42,000	44,500
4.Dental training hospitals	94,479	107,490	109,246	111,100	117,700	122,896
etc						
Total programme	1,288,405	1,368,349	2,137,205	2,302,890	2,469,871	2,586,596

Staff Costs *1,484,700 equals 64% of Total expenditure*

Pharmaceuticals *135,600 equals 6% of Total expenditure*

4.1 Sub Programme : General (Regional) Hospitals

Situation analysis

The integrated planning framework provides a multi-year flagship with focus on service delivery, and improved implementation. There are 13 regional hospitals in Gauteng province to sustain the planned goals, objectives and priorities for financial year 2003/2004 and beyond.

Ekurhuleni metro due to its proximity to the major freeways to Durban-Swaziland and interconnecting the airport has a high accident rate. Germiston area, in particular, has receives more trauma in the Province.

Table: Performance indicators for general (regional) hospitals

Indicator	Province wide value 2001/02	Hospital range	National target
Input			
Expenditure on hospital staff as percentage of total hospital expenditure	✓	✓	
Expenditure on drugs for hospital use as percentage of total hospital expenditure	✓	✓	
Expenditure on hospital maintenance as percentage of total hospital expenditure	✓	✓	
Useable beds per 1000 people*	0,9		
Useable beds per 1000 uninsured people*	1,2		
Hospital expenditure per person*	R 123		
Hospital expenditure per uninsured person*	R 166		
Process			
Percentage of hospitals with operational hospital board	✓		
Percentage of hospitals with appointed (not acting) CEO in place	✓		
Percentage of hospitals with business plan agreed with provincial health department	✓		
Percentage of hospitals with up to date asset register	✓		
Maximum permitted value of procurement at discretion of hospital CEO without reference to provincial level	✓	✓	
Output			
Separations per 1000 people*	✓		
Separations per 1000 uninsured people*	✓		
Patient day equivalents per 1000 people*	284		
Patient day equivalents per 1000 uninsured people*	385		
Patient fee income per separation	✓	✓	
Quality			
Percentage of hospitals in facility audit condition 4 or 5	✓		

Percentage of hospitals that have conducted and published a ppatient satisfaction survey in last 12 months	✓		
Percentage of hospitals with designated official responsible for coordinating quality management	✓		
Percentage of hospitals with clinical audit (M&M) meetings at least once a month	✓		
Efficiency			
Average length of stay	4,8	✓	
Bed utilisation rate (based on useable beds)	69,9	✓	
Expenditure per patient day equivalent	R 432.8	✓	
Outcome			
Case fatality rate for surgery separations	✓	✓	

✓*Data still being collected or verified*

Appraisal of existing challenges of hospitals (excluding academic facilities) for 2001/2002

Patient care management

- Long waiting period
- High patient day equivalent
- Relative more patients' complaints
- Increasing HIV/AIDS patients in facilities
- Consolidation of occupational health safety and establishment of HIV/AIDS committees
- Improvement of referral management
- Develop and implementation of "norms and standards" package for district and regional hospitals
- Speeding up the delivery of step down beds in regional hospitals

Human resource management

- Lack of finalized human resource plans
- High staff turnover
- Perceived low staff morale, motivation and commitment
- Lack of acceptable performance management system

Financial management

- Failure to stay within the limit of budget allocation and prevention of over-expenditure
- Containing cost drivers (laboratory, blood and blood-products, maintenance of medical equipment, transport, telephones and security services)
- Rolling out the cost center management
- Implementing the fraud prevention plan and improving management of losses

Facility planning and management

- Provision of quality hotel facilities
- Completion of projects initiated for buildings and major equipment
- Maintaining beautiful, safe and clean hospital environment

Community involvement

- Strengthening the relationship between the hospital and hospital board
- Involving the community in health promotion and education

4.1.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

Policies, broad objectives

- The overarching principle is improving acute care and making shifts to Primary Health Care (PHC).
- Regional hospitals are gearing at strengthening the PHC through referral networks, outreach programme strategy and support of Maternal Mortality Review (MMR) committees. Increasing of psychiatric and step-down beds in the regional hospitals
- Batho-pele principles and Gauteng Service Pledge provide guidance in relating with communities and staff.
- Increasing the district hospitals in support of district health services within the context of District Health System (DHS)

- Delegations

Decentralization principles need to be observed as a guide in managing delegation and legislative imperatives. The following functions or management areas are delegated to the hospitals in promoting efficiency, effective and value for money in the facilities and the Department: Finance, Procurement and Human resource.

- Governance and accountability

The decision-making processes in the hospitals are informed and facilitated by both the Hospital Boards and Management. Hospital board members and Chief Executive Officers are appointed in all hospital in consolidating the governance and accountability in hospitals.

- Management systems

Implementing the cost center management strategy within the roll-out processes
Strengthening integrated management information system within consolidation of implementation minimum data set.
Refining capacity building for middle management in effecting cost center management requirements

4.1.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Constraints	Interventions for 2003/2004
Declining work ethics and commitment	- Speeding up the implementation of employees assistance programme - Encouraging patriotism and commitment
Deficient resource management	- Monitoring compliance to delegations, policies, procedures and legislations - Capacity improvement through development strategies
Non-established HIV/AIDS in the workplace	- All facilities to establish functional AIDS Workplace with inclusion of Employees' Assistance Programme - Marketing and implementing the GPG HIV/AIDS strategic framework
Incomplete appraisal system	Facilities to continue monitoring performance on a quarterly basis
Inadequate information systems and coordination	Consolidating the management and implementation of minimum data set
HIV/AIDS workloads impact illness due to absenteeism	Speeding up the implementation of Employees Assistance Programme
Percentage of labour instability in few institutions	Intensify capacity building on labour relations for frontline and middle managers
Lack of capacity by managers to interact with unions	Intensify capacity building on labour relations for frontline and middle managers
Inadequate revenue systems	- Develop new initiatives or allow creative approaches of revenue generation - Step-up the public-private partnerships or initiatives
Cross border patients and cost incurred	Continual consultation and communication with neighbouring cross border provinces on cost management

4.1.4 DESCRIPTION OF PLANNED QUALITY IMPROVEMENT MEASURES

- Improving the management of patient care through reduction of waiting time and productive helpdesk or information desk
- Implementing clinical management treatment guidelines
- Ensuring that patient complaints are managed proficiently
- Improve the efficiency hospital indicators (ALOS and BOR)
- Formation or consolidating the quality auditing system for multidisciplinary clinical management

4.1.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table: Measurable objectives and evolution of performance indicators for regional hospitals

Strategic Objectives	Measurable Objective	Indicator[1]	2001/02 (actual)[2]	2002/03 (estimate)[2]	2003/04 (target)	2004/05 (target)	2005/06 (target)
Strengthen community participation and maintenance of infrastructure and equipment	Establish hospital boards in the hospitals	Percentage hospitals with operational hospital board established	70	100	100	100	100
Revitalisation of hospital services	Develop a business for the hospital *(Service plan)*	Percentage of hospitals with business plan agreed with provincial health department	#	#	30	100	100
Improve financial management	Ensure delegated functions to CEO of the hospitals	Maximum permitted value of procurement at discretion of hospital CEO without reference to provincial level	#	#	Data still being verified		
Improve quality of care	Conduct and publish patient satisfaction survey annually	Percentage of hospitals conducted and published patient satisfaction survey in the last 12 month	#	#	80	100	100
	Ensure coordination of quality management in hospitals	Percentage of hospitals with designated official responsible for coordinating quality management	#	#	100	100	100

	Establish clinical audit in all hospitals	Percentage of hospitals with clinical audit (M&M meetings at least once a month	#	#	70	90	100
Equitable distribution of resources	Ensure hospital utilisation	Usable beds per 1000 people Useable beds per 1000 uninsured Patient day equivalent (PDE) per 1000 people Patient day equivalent (PDE) per 1000 uninsured people Separation per 1000 people Separation per 1000 uninsured people Case fatality rate for surgery separation	Data still being verified		Still to be determined		
Equitable distribution of resources	Ensure hospital efficiency	Expenditure on hospital staff as percentage of total hospital expenditure Expenditure on drugs for hospital use as percentage of total hospital expenditure	Data still being verified		Still to be determined		

		Expenditure on hospital maintenance as percentage of total hospital expenditure Patient fee income per separation Hospital expenditure per person Hospital expenditure per uninsured person					

1. *# New indicator: information not available*
2.Used 1996 census data

4.2 SUB PROGRAMME : TUBERCULOSIS HOSPITALS

4.2.1 SITUATION ANALYSIS

Gauteng health department provide TB care services through six private aided and contracted hospitals. During the past year the department was maintaining a total of 675 contracted TB beds in SANTA and Life care hospitals and currently we have 1496 beds.

Table: Private aided/contracted hospitals

Name	No. of Beds	Bed occupancy rate	Average length of stay	Patient days	admissions
SANTA hospitals					
Charles Horwitz	350	70%	63 days	87923	1395
East Rand SANTA	350	80%	90 days	101285	1118
Shaping SANTA	120	73%	65 days	40605	566
Life CARE hospitals					
Lifemed	175	95%	50 days	60598	2040
Knights Chesl	350	78%	4 days	99318	3689
Randfontein South	150	88%	55 days	47996	1820
Grand Total	**1495**	**84%**	**63days**	**437725**	**10628**

4.2.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

Broad strategic objectives

- To ensure effective utilization of TB Hospitals

Priorities

- To facilitate 90% occupancy of TB Hospital
- To ensure HIV/TB collaboration and optimal care
- Maintaining of TB the number of contracted beds in private hospitals

4.2.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

- National review of Lifecare and SANTA Hospitals in 2001 indicated

mismanagement of funds by SANTA National. Measures planned to overcome the problem is to strengthened admissions and discharges
- Underutilization of hospital beds – strengthen admission and discharge and Referrals to and from Province Hospitals as well as TB Hospitals.
- Inefficient financial system- system develop
- Patient more ill – training and fund for
- Inadequate monitoring system- system
- No contractual services with sending after stepping management fee to SANTA National – fund as NGO

4.2.4 DESCRIPTION OF PLANNED QUALITY IMPROVEMENT MEASURES

Description will be provided with the final strategic plan.

4.2.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table: Measurable objectives and evolution of performance indicators for Psychiatric hospital

Strategic objectives	Measurable Objective	Indicator[1]	2001/02 (Actual) [2]	2002/03 (Estimate) [2]	2003/04 (Target)	2004/05 (Target)	2005/06 (Target)
Equitable distribution of resources	Ensure maintenance of TB patients beds care for by private institution	Number of TB beds maintained	675	675	1495	To be reviewed	To be reviewed
	Improve hospital utilisation	Number of admissions	10628	10628	20 000	20 000	20 000
		Patient day equivalent	437725	437725	60 000	60 000	60 000
	Ensure hospital efficiency	Average Length of stay (ALOS)	63 days	62 days	55	53	50 days
		Bed Occupancy Rate (BOR)	80	80	82	85	85

4.2.6 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLA

Table: Evolution of expenditure by budget programme and sub-programme in current price (R million) ***for Private Aided/Contracted hospitals***
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Sub-programme	**2000/01 (actual)**	**2001/02 (actual)**	**2002/03 (actual)**	**2003/04 (budget)**	**2004/05 (MTEF projection)**	**2005/06 (MTEF projection)**
Randfontein South	554477	6656079	6507038	6738219	720989	7714587
Lifemed	6395022	7208732	7591543	7861255	8411543	9000352
Knights	12090318	12454381	13664778	15722511	16823086	18000702
Tshepong	3451425	2567410	3869730	4081941	4367677	4673414
Etc cha unites	7221550	7473455	10692675	11905661	12739057	13630790
	8007384	8609225	10692675	11905661	12739057	13630795
Total	**41828161**	**45853297**	**53018439**	**58215198**	**62290315**	**66650635**

4.3 SUB PROGRAMME : PSYCHIATRIC HOSPITALS

4.3.1 SITUATION ANALYSIS

Gauteng render psychiatric/mental hospital services through four psychiatric provincial hospitals with 2352 beds and 8 psychiatric contracted hospitals with 3500 beds
Mental disorders are common, and constitute a significant component of the burden of disease. Local and international studies indicate that one in four people is likely to develop a mental illness over the course of their lifetime[1]. Mental illnesses are also estimated to contribute 10% to the global burden of disease, and this is predicted to increase over the next 10 years[2]. Serious mental illnesses such as psychotic and severe mood and anxiety disorders affect 3% of the population. These conditions are disabling and chronic, and constitute a significant drain on health services and the economy as a whole. Many of these disorders are treatable with modern medications and psychosocial interventions, which can also minimize the extent of disability.

In assessing mental health services against population, account must be taken of the fact that there are very few private facilities for the treatment and care of people with severe psychiatric disorder, particularly in the case of chronic conditions. Hence the total population of Gauteng must be considered. Furthermore, Gauteng continues to have to provide forensic services for cases referred from adjacent provinces. It should also be noted that mental health services are provided not only in specialised hospitals, but also in general hospitals and, in the case of chronic care, through a contracted provider.

Taking into account the above, mental health services in Gauteng are inadequate in terms of facilities and staffing. There are insufficient acute beds (0.15/1000 compared with national target norm of 0.25/1000) and the physical condition of many facilities is poor. There has been a significant loss of mental health professionals, particularly psychiatrists and psychiatric nurses, from the service in the last 2 years. There is a continuing shortage of allied health professionals. As a result of lack of integration of mental health into primary care, there is inadequate early identification of mental disorders (pick-up rate of 0.16% compared with expected 10% of cases in PHC), with patients using higher levels of care as the first entry point. Chronic care services (most of which are provided on a contracted basis) are primarily institutional and custodial, with an inherited backlog of patients with lengths of stay in excess of 10 years. Community-based services are currently inadequate to provide the necessary care and supervision for discharged chronic patients (particularly those with a long history of institutionalization) in order to prevent relapse and re-admission. The continued use of Gauteng forensic services by adjacent provinces places pressure on these services.

Staffing accounts for a high proportion of costs in specialised hospitals (74.7%), with expenditure on drugs a relatively modest percentage (4.4%). Useable beds per 1000 population in specialised hospitals should be seen in the context of the fact that there are also acute beds in general hospitals (see figure given above), while a larger number of chronic beds (for both psychiatric disorders and intellectual disability) is provided in contracted care than in specialised hospitals (with a total of chronic beds per 100 population increasing to 0.55/1000 when the former are included).

[1] World Health Report 2001: Mental Health: New Understanding, New Hope. WHO, Geneva, 2001.
[2] WHO Global Burden of Disease report 2000. WHO Geneva.

Table: Performance indicators for specialised psychiatric/mental hospitals

Indicator	Province wide value#	Range
Input		
Expenditure on hospital staff as percentage of total hospital expenditure	74.67%* (80.18%)	64-86% (64-96.7%)
Expenditure on drugs for hospital use as percentage of total hospital expenditure	4.4% (3.34%)	2.16-7% (0.15-7%)
Expenditure on hospital maintenance as percentage of total hospital expenditure	1.80%	0.9-3.6%
Useable beds per 1000 people: Acute	0.10	
Useable beds per 1000 people: Chronic	0.08 (0.11)	
Useable beds per 1000 people: Forensic (state/observation)	0.07	
Useable beds per 1000 uninsured people	N/a	
Hospital expenditure per person	R22.51 (R25.30)	
Hospital expenditure per uninsured person	N/a	
Process		
Percentage of hospitals with operational hospital board (in terms of new legislation)	N/a	
Percentage of hospitals with appointed (not acting) CEO in place	50%	
Percentage of hospitals with business plan agreed to by provincial health department	50%	
Percentage of hospitals with up to date asset register	100%	
Maximum permitted value of procurement at discretion of hospital CEO without reference to provincial level	R1 000 000	
Output		
Separations per 1000 people	0.89	
Separations per 1000 uninsured people	N/a	
Patient day equivalents per 1000 people	0.2 (0.24)	
Patient day equivalents per 1000 uninsured people	N/a	
Patient fee income per separation	R2006.19**(R2005.10)	R451.23-R3228.81

Quality		
Percentage of hospitals in facility audit condition 4 or 5	75%	
Percentage of hospitals that have conducted and published a patient satisfaction survey in the last 12 months	0%	
Percentage of hospitals with clinical audit meetings at least once a month	75%	
Efficiency		
Average length of stay - acute beds	65	55-75
Average length of stay - chronic beds	270 (301)	270 (270-365)
Average length of stay - State patients***	715	700-730
Bed utilisation rate (based on useable beds): Acute	75.85	
Bed utilisation rate (based on useable beds): Chronic	77.52 (85.01)	64-91 (64-100)
Bed utilisation rate (based on useable beds): State	80.14	66-94
Expenditure per patient day equivalent	R307.53 (R291.63)	R247.22-R559.68

National targets applicable across a wider range of hospitals (e.g. general) than shown in this table

N/a: Very few private services/limited medical aid for severe mental illness; hence public sector responsible for virtually all patients

*First figure: 3 specialised psychiatric hospitals only; figure in brackets incl. spec. hospital for intellectual disability

** Patient fee income boosted in two specialised hospitals by income derived from observation patients

*** Length of stay of state patients partially dependent on decision of Justice Department officials

Key challenges over the strategic plan period

The key challenges includes
the implementation of the new Mental Health Care Act (in 2003),

maintaining existing services in the light of budgetary and human resource constraints as well as the impact of HIV/AIDS on mental health services,

Making efforts to provide at least a minimum of in- and out-patient services for children and adolescents with psychiatric disorders,

effecting rationalization of institutional chronic care,
developing district (particularly primary mental health care) services, and

strengthening partnerships with non-governmental organizations to assist in the provision of community-based care for people with mental disorders, especially in the light of pressures to reduce chronic care beds.

4.3.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

National and provincial mental health policies have been developed and approved. These are also linked to the provincial strategic plans and the national Ten Point Plan. Basically, the provincial mental health policy spells out the need to:

- Develop a comprehensive mental health service at all levels of care, both in the district and hospital services, and ensure that mental health services are available and accessible to the community, as close to their homes as possible.
- Improve early detection, treatment and care in order to minimize the long-term effects of mental disorders.
- Reduce institutional care for people with chronic mental disorders and increase community-based care.
- Improve mental health services for children and adolescents.
- Promote mental health and a human-rights approach to dealing with people with mental disorders.

4.3.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Mental health services have been underdeveloped and marginalized in the past. This continues in the present, where expenditure on mental health services is low compared to the demand and burden of disease. As a result, people with mental disorders remain untreated and it is difficult to obtain an adequate quality of care in facilities for those who are able to access treatment.

Budgetary constraints on health services in general are impacting on maintaining even current service levels, let alone improving them. Attrition of staff, particularly experienced staff (due to emigration and movement to the private sector) has left our services being run largely by inexperienced and junior staff. Some categories of staff within the health service are extremely scarce (allied medical professionals).

The only way to improve the situation is for mental health services to be a departmental priority for development. This requires ongoing advocacy on the part of the programme

concerned. However, the ultimate decisions and outcomes are not under the control of the programme, but lie with the senior management of the Department.

A major challenge in 2003 will be the implementation of the new Mental Health Care Act. This requires additional expenditure by the department in terms of the establishments of Mental Health Review Boards, as well as in developing services.

4.3.4 DESCRIPTION OF PLANNED QUALITY IMPROVEMENT MEASURES

Existing quality improvement measures, primarily through regular audits and promoting staff training, will continue. However, the major challenge is to try to prevent further deterioration of services in the light of the constraints mentioned above, in particular, staff attrition and budgetary constraints.

4.3.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table: Performance indicators for mental health services in Gauteng province

Strategic Objectives	Measurable Objective	Indicator	2001/2	2002/3 (estimate)	2003/4 (target)	2004/5 (target)	2005/6 (target)
Strategic Objectives	Develop a comprehensive mental health service at all levels of care, both in the district and hospital services.	Number of mental health professionals (public sector)/100 000 population (per category of staff)	All below the national norms	All below the national norms	Within 20% of national norms	Within 10% of national norms	Within national norms
		Number of health facilities that provide a secondary level mental health service in the district health service.	85	85	85	85	85
		District mental health staffing/District specialist multidisciplinary mental health teams in the province.	All below the national norms	All below the national norms	Within 20% of national norms	Within 10% of national norms	Within national norms
		The number of general hospitals that have a secondary level acute psychiatric unit.	7	8	9	10	11
		Bed ratios: acute beds/100 000 population	16	16	16	16	16
		Bed occupancy rates: acute beds	79%	75%	83 to 85%	83 to 85%	83 to 85%

		Average length of stay rates: acute beds in general hospitals acute beds in specialized hospitals	15 days unknown	16 days 60 days	14 to 17 days 60 days	14 to 17 days 60 days	14 to 17 days 60 days
Promote mental well-being and improve early diagnosis, treatment and support to people with mental illness	Improve early detection, treatment and care to minimize the long-term effects of mental disorders.	Detection rate of acute mental disorder in PHC clinics:	<1%	<1%	2%	3%	5%
	Improve mental health services for children and adolescents	The number of specialised child mental health clinics in each region	18	18	18		
	Reduce institutional care for people with chronic mental disorders and increase community-based care.	Percentage of chronic stable patients with mental illness seen in PHC service for follow-up treatment.	1.6%	1.6%	3%	5%	7%
		Number of beds reduced in private institutions for patients with chronic mental illness	3590	3400	3300	3200	3125
		Number of chronic care beds in specialised hospitals	912	900	800	700	650

		Number of NGO day and residential care places for severe psychiatric disability	310 310	350 335	390 365	430 395	470 425
		Number of NGO day and residential care places for intellectual disability	968 1410	980 1420	1000 1430	1020 1440	1040 1450
	Ensure minimum standards of care and accountability in contracted and NGO-provided chronic care facilities	Number of scheduled and unscheduled audits of contracted care facilities per annum	8 8	8 8	8 8	8 8	8 8
		Percentage of NGO licenses withheld for quality or financial reasons	0%	<1%	<1%	<1%	<1%
		Number of NGO staff attending GHD-sponsored training courses	25	75	100	120	150

4.3.6 Past expenditure trends and reconciliation of MTEF projections with plan:

Central Office Budget & Expenditure:

Hospital & Community Mental Health Services

Budget

2001/2	2002/3	2003/4
R626 000	R160 000	R3 166 100

A full expenditure record is not available for 2001/02 or 2002/03, due to accounting falling under the control of Directorate Financial Control and lack of feedback to this Directorate. However, the full budget for 2001/02 was not spent. The budget for 2003/4 includes an additional R3 million for the establishment and implementation of Mental Health Review Boards.

Project on Chronic Mental Health Care

Budget (derived from savings from budget for contracted care)

2001/2	2002/3	2003/4
R5 673 750	R9 160 097	R13 866 900

With expenditure for 2001/02 at R1 403 146, there was significant under-spending. This was largely due to late appointment of Project staff and slow growth in NGO provision (subsidies for which constituted the greater part of the budget). In consequence, the budget for 2003/04 has been scaled down from previous MTEF projections.

Contracted care payments

Budget

	2001/2	2002/3	2003/4
MTEF amounts (incl. Project budget)	R149 000 000	R155 000 000	R167 000 000
Revised projections taking into account bed reductions (excl Project budget)	R139 500 000	R145 529 542	R152 952 972
Expenditure	R127 417 214		

Lower than expected expenditure was primarily due to occupancy less than expected, as well as delays in shifting patients, resulting in lower overall tariff payments.

Hospital and District Health Services
Expenditure by mental health services in the district health service and in general hospitals is not recorded separately.

Specialised hospitals

	2001/2
Budget	R 201 968 000*
Expenditure	R 196 946 732

* Does not include additional budget amounts e.g. building maintenance/renovation

4.4 SUB PROGRAMME : DENTAL TRAINING AND OTHER SPECIALISED HOSPITALS

4.4.1 SITUATION ANALYSIS

Gauteng has three academic dental hospitals providing oral health services to the population of Gauteng and neighbouring provinces and one specialised health care for infectious diseases.

ND: The information required for situational analysis is still being collected, and will be presented with the final strategic plan

4.4.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

Broad strategic objectives

- Rationalisation of academic dental hospitals
- Strengthen oral health services
- Ensure effective and efficient utilization of resources

4.4.2 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Analysis will be provided in the final strategic plan.

4.4.4 DESCRIPTION OF PLANNED QUALITY IMPROVEMENT MEASURES

Description will be provided in the final strategic plan.

4.4.5 Specification of measurable objectives and performance indicators

Table: Measurable objectives and performance indicators for Academic dental hospitals and Specialised hospital

Strategic Objectives	Measurable Objective	Indicator[1]	2001/02 (actual)[2]	2002/03 (estimate)[2]	2003/04 (target)	2004/05 (target)	2005/06 (target)
Strengthen community participation and maintenance of infrastructure and equipment	Establish hospital boards in the hospitals	Percentage hospitals with operational hospital board established	33	33	33	100	100
Revitalisation of hospital services	Develop a business for the hospital *(Service plan)*	Percentage of hospitals with business plan agreed with provincial health department	#	#	50	100	100
Improve quality of care	Conduct and publish patient satisfaction survey annually	Percentage of hospitals conducted and published patient satisfaction survey in the last 12 month	#	#	50	100	100
	Ensure coordination of quality management in hospitals	Percentage of hospitals with designated official responsible for coordinating quality management	#	#	33	50	100
	Establish clinical audit in all hospitals	Percentage of hospitals with clinical audit (M&M meetings at least once a month	#	#	50	100	100

	Improve hospital utilisation	Number of out patients Number of admissions Patient day equivalent (PDE) Cost per PDE	37694 Data still being verified	37694	43694 Still to be determined	46 000	48 000
Equitable distribution of resources	Ensure hospital efficiency	Expenditure on hospital staff as percentage of total hospital expenditure Expenditure on drugs for hospital use as percentage of total hospital expenditure Expenditure on hospital maintenance as percentage of total hospital expenditure Hospital expenditure per person	Data still being verified		Still to be determined		

PROGRAMME 5: CENTRAL HOSPITAL SERVICES

5.1 SITUATION ANALYSIS

Gauteng has 4 central hospitals with approved beds of 6767 providing services for Gauteng population including neibouring provinces and African countries.

The strategy of the department is to shift 1400 level 1 bed to the lower levels of care over the next two financial years. It is estimated that of the total usable beds, 20% are level 1 beds.

Tables: Number of beds in central hospitals by levels of care

Central hospital (or complex)	No. of level 3 / 4 beds	No. of levels 1 and 2 beds	Total no. of beds
C.H Baragwanath	819	1967	2786
Johannesburg	500	610	922
Ga-Rankwa	361	1363	1163
Pretoria	556	366	1724
Total usable beds	**2236**	**4306**	**6563**
Total approved beds			*6767*

Appraisal of existing services and performance during the part year

Over the past year the following achievements have been made:

- The average length of stay for central hospitals is 7.5 days, below the national average of 6.6 days and bed occupancy rate (BOR) of 74.7% that is within the national norm of 70-80%.

- Over the past year Chief Executive Officers (CEO's) have been appointed in all the central hospitals with 94% of top management posts filled.

- Outreach programmes has been established at Sizwe Hospital , South Rand Hospital, Thambo Memorial, Kalafong hospital, Helen Joseph, and Edenvale Hospital

Table: Performance indicators for central hospitals

Indicator	Province wide value 2001/02	Hospital range	National target
Input			
1. Expenditure on hospital staff as percentage of total hospital expenditure	✓	✓	
2. Expenditure on drugs for hospital use as percentage of total hospital expenditure	✓	✓	
3. Expenditure on hospital maintenance as percentage of total hospital expenditure	✓	✓	
4. Useable beds per 1000 people*	0,9		
5. Useable beds per 1000 uninsured people*	1,2		

6. Hospital expenditure per person*	R 419,8		
7. Hospital expenditure per uninsured person*	R 568,8		
Process			
8. Percentage of hospitals with operational hospital board	✓		
9. Percentage of hospitals with appointed (not acting) CEO in place	✓		
10. Percentage of hospitals with business plan agreed with provincial health department	✓		
11. Percentage of hospitals with up to date asset register	✓		
12. Maximum permitted value of procurement at discretion of hospital CEO without reference to provincial level	✓	✓	
Output			
13. Separations per 1000 people*	✓		
14. Separations per 1000 uninsured people*	✓		
15. Patient day equivalents per 1000 people*	312,6		
16. Patient day equivalents per 1000 uninsured people*	423,5		
17. Patient fee income per separation	✓	✓	
Quality			
18. Percentage of hospitals in facility audit condition 4 or 5	✓		
19. Percentage of hospitals that have conducted and published a ppatient satisfaction survey in last 12 months	✓		
20. Percentage of hospitals with designated official responsible for coordinating quality management	✓		
21. Percentage of hospitals with clinical audit (M&M) meetings at least once a month	✓		
Efficiency			
22. Average length of stay	7.5	✓	
23. Bed utilisation rate (based on useable beds)	74.7%	✓	
24. Expenditure per patient day equivalent	R 1343	✓	
Outcome			
25. Case fatality rate for surgery separations	✓	✓	

✓*Data still being collected or verified*

5.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

The main purpose of this programme is to provision of highly specialised health services to Gauteng residents and referred patients from other provinces and to Provide of a platform for the training of health workers

Broad objectives

- Shift in levels of care (level 1 care from central hospitals)
- Ensure appropriate use of services and reduction of service backlog at academic institutions
- Rationalisation of highly specialised units
- Provide efficient and effective clinical support
- Provide high quality and user-friendly hotel facilities
- Ensure equitable and efficient distribution and use of resources
- Provide quality of service

5.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Analysis will be provided with the final strategic plan.

5.4 DESCRIPTION OF PLANNED QUALITY IMPROVEMENT MEASURES

The quality improvement programme for central hospitals has been presented in the strategic plans for each academic hospital and in the quality improvement section in programme 1.

5.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table: Measurable objectives and evolution of performance indicators central hospitals

Strategic Objectives	Measurable Objective	Indicator[1]	2001/02 (actual)[2]	2002/03 (estimate)[2]	2003/04 (target)	2004/05 (target)	2005/06 (target)
Revitalisation of hospital services	Shift of level 1 beds from central hospitals	Number of separate level 1 bed established	#	#	700	700	-
	Re-organized highly specialized units for improved efficiency e.g. -Cardio thoracic -Oncology unit -Orthopaedics	Percentage completion of re-organized units	#	#	80	100	100
	Strengthened and capacitated management team in hospital	Percentage filled top management posts	#	94	100	100	-
	Ensure provision of outreach programmes by academic medical staff to secondary and other hospitals	Number of outreached programmes maintained	6	6	6	6	6

	Shift primary ambulatory care patient from central hospitals to level 1 facilities	Percentage shift completed	#	#	100	-	-
Improve quality of care	Ensure shorter waiting times for patients	Percentage of hospitals measuring waiting times	#	90	100	100	100
		Percentage reduction in overall waiting times	#	#	10	15	20
	Reduce waiting list of highly specialized surgery	Percentage reduction in waiting list for cataract, hip replacement and cardiothoracic surgery	#	#	10	20	20
Equitable distribution of resources	Improve hospital utilization	Number of beds available	6532	6532	4791	4144	3877
		Number of admissions	276054	276054	276 882	235 350	200 050
		Admissions per 1000 uninsured	50.8	50.8	50.9	50.9	50.9
		Number of out	1703723	1703723	1362178	1157851	984 173

		patients Patient day Equivalent (PDE's)	2303140.7	2303140.7	2100050	1785042	1517286
	Improve hospital efficiency	Average length of stay (ALOS)	7.5	7.5	7	6	6
		Bed Occupancy Rate (BOR)	74.7	74.7	75	80	80
		Cost per PDE	R1343	R1343	R1347*	R1240*	R1200*

**Estimates*
 # New indicator, data not available

5.6 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Table: Evolution of expenditure by budget programme and sub-programme in current prices (R million)[1]

Sub-programme	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)	2004'05 (MTEF projection)	2005/06 (MTEF projection)
1. Chris Hani Baragwanath Hospital	681,269	755,702	925,532	800,000	821,000	870,500
2. Johannesburg Hospital	673,040	681,301	803,086	722,000	741,000	786,000
3.Pretoria Academic Hospital	534,168	572,706	575,343	563,000	577,500	612,500
4. Ga Rankuwa Hospital	454,377	488,102	520,789	498,000	511,000	542,000
etc						
Total programme	2,343,209	2,497,811	2,824,750	2,583,000	2,650,500	2,811,000

Table: Evolution of expenditure of budget programme in constant 2002/03 prices (R million)[1]

Expenditure	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	Average annual change (%)	2003/04 (budget)[2]
Total[3]	2,343,209	2,497,811	2,824,750		2,583,000
Total per person[4]	318.05	339.04	383.42	0.00	350.60
Total per uninsured person[5]	430.89	459.32	519.44	0.00	474.98

5.1 SUB PROGRAMME: GARANKUWA HOSPITAL

5.1.1 SITUATION ANALYSIS

Ga-Rankuwa hospital is the tertiary academic hospital attached to the Medical University of Southern Africa. It is a large hospital with 1724 approved beds. As such, the hospital mission includes training and research in addition to service requirement.

Medunsa, the associated university is the largest undergraduate medical school in the country, hence produces the vast majority of black medical practitioners into the South African health environment.

It is significant to note that all of the nine faculties of Medicine in this country, have or are in the process of acquiring modern tertiary hospitals. The only exception is the Medical University of Southern Africa. Ga-Rankuwa hospital was not built as a tertiary hospital and has never had the facilities required for an academic hospital. There are no doctors' offices, no seminar rooms, no lecture rooms and inadequate and outpatient facilities for the services which we are expected to provide. Furthermore, the wards are not well designed for tertiary services and the layout of the hospital is not conducive to quality care and nor meet minimum safety requirements.

Fortunately there are discussions to refurbish existing wards and construct a new out- patient and an emergency department.

Appraisal of existing services and performance during the past year

Due to its location, the hospital provides comprehensive services covering all three levels of care, and serves a wide catchment area comprising of all the surrounding provinces. All major specialist services are provided on site except radiation oncology and heart transplantation.

The majority of patients who visit outpatient departments are treated as they come without prior booking. Referral letters do not indicate the discipline that should treat the patients. This result in casualty being used as triage area to direct patients, which obviously is inappropriate because it diverts attention from genuine emergency patients.
A substantial proportion of these patients could adequately and safely be treated at peripheral hospitals or clinics.
There is a need to develop appropriate referral guidelines in collaboration of all key stakeholders, and establish a booking system for specialist consultations. This will greatly reduce queuing time in hospitals. The recently adopted concept of cluster of facilities referring to an academic hospital will be the forum where integrated care pathways will be developed.

To provide more seamless care the region should consider developing or outsourcing step-down and hospice beds to house patients who not require care in an acute setting. This will reduce the overall length of stay in the hospital and reduce pressure on beds in certain departments such as medicine. Home based care, accepted as a cost effective strategy for terminally ill patients suffering from Aids should also be instituted.

The impact of the epidemic is the substantial increase in the number of admission particularly in the department of medicine and paediatric. It also increases the severity of related conditions. As a result the treatment is both prolonged and more expensive.
It is therefore important to investigate the options of providing palliative care for these patients in hospices and homes in order to free beds in the hospital.
There is HIV clinic on site, which treats new and followed up patients. A processs is underway to devolve follow up patients to local clinics and community health centers. The patients will come to the hospital only if they complicate.

Tuberculosis is amongst the most prevalent opportunistic infection associated with HIV. There is an increase in the number of patients admitted due to TB. There is also a great suspicion of nosocomial transmission of TB in the department of medicine in view of higher proportion of tuberculosis diagnosed on patients previously admitted for other conditions.

Pharmacy services.
The pharmacy service is usually downstream of all operations in the hospital. This implies that any inefficiency upstream results in major bottlenecks at the pharmacy. There is only one area doing dispensing for the whole hospital. Patients are cramped in a small waiting area, which compromises the quality of care. The shortage of pharmacists has been alleviated by the introduction of community pharmacists. The budget for available for drugs is relatively is too tight and may be under more pressure as the scope of oncology services may be expanded. The lack of basic medication in the district services exacerbates the situation.
While there is a plan to build adequate waiting areas in the new outpatient department, consideration is being given to opening a satellite dispensary to decongest the current area.

Nursing

Nursing is the backbone of quality in any hospital service. The nursing number in general wards is relatively acceptable. However there is a need to beef up numbers in specialist areas such as intensive care and theatres. This is crucial if we are to maintain the current downward trend in the use of nursing agencies.

Management information system

The need for accurate and timeous information has come to the fore as we attempt to compile the strategic plan in the required format. This has again highlighted the weakness in our information system. A concerted effort and coordinated from the directorate of information is necessary to develop systems to retrieve information in agreed formats. Data capturers initiated in elementary medical lexicology will be necessary to set up clinical information system and set the pace for patients electronic records.
Linking of the hospital system to the pathology system needs to be fast tracked.

The impact of trauma

Trauma due to interpersonal violence and motor vehicle accident places a lot of burden on surgical disciplines. There is a need to establish a trauma unit with a high care /ICU to improve outcomes in major poly-trauma and other seriously injured patients.
This unit should also have a dedicated theatre in order to address the current backlog experienced in orthopedic department. A serious attempt should be made to recover money from the road accident fund in respect of the treatment provided to victims of motor vehicle accidents.

Table: Staff Establishment

Category	Number Employed	Vacant Posts	% age of Employees	Cost per Annum	% age of Total Cost
Medical Interns	35	0	0.99%	R 5 490 450	1.50%
Medical Officers	91	15	2.57%	R 21 759 704	5.95%
Registrars	130	39	3.68%	R 35 611 550	9.73%
Specialists & Senior Specialists	83	43	2.35%	R 19 674 276	5.38%
Principal & Chief Specialists	35	14	0.99%	R 17 760 810	4.85%
Student Nurses	124	0	3.51%	R 7 960 180	2.18%
Nursing Assistants	435	24	12.31%	R 26 661 367	7.29%
Staff Nurses	308	64	8.71%	R 24 741 332	6.76%
Professional Nurses	310	3	8.77%	R 32 841 555	8.98%
Chief Professional Nurses	430	69	12.16%	R 59 628 960	16.30%
Pharmacist Interns	4	0	0.11%	R 385 852	0.11%
Pharmacists	13	1	0.37%	R 1 790 484	0.49%
Allied Health Professionals	126	37	3.56%	R 13 068 502	3.57%
Managers & Administrators	29	3	0.82%	R 7 154 199	1.96%
Directors	4	0	0.11%	R 1 664 606	0.45%
Support Staff	1378	218	38.98%	R 89 663 868	24.51%
Total	**3535**	**530**	**100.00%**	**R 365,857,695**	**100.00%**

Cross Border Flows

As regards inter-provincial flows of patients, Medicom is not able to retrieve information neither per discipline nor for inpatient. The table below displays the breakdown per province of origin of patients registered on Medicom for the past three months. It shows that about 50% patients of patients treated at Ga-rankuwa hospital come from the three surrounding provinces, provided that patients gave the correct information.

Table3. Cross Border Flows

	August	September	October	Total
Gauteng	3795	3950	3936	11681
North West	1943	1956	1955	5854
Limpopo	792	836	684	2312
Mpumalanga	786	894	716	2396
Total	**7316**	**7636**	**7291**	**22243**

The referral route remains as proposed in the policy developed the province in 1998 a part from Jubilee hospital, which Pretoria academic hospital feels should refer to us. Discussions will be held soon to finalise the proposal.

Services Rendered

Other than radiation oncology, the hospital provides a comprehensive service including all major specialist services. We will continue to provide the current range of services until Oddi and Brits hospitals are able to take over services that are rightfully theirs. A plan will be submitted to the region to request hospice beds for terminally ill aids patients.
The hospital accepts the need to rationalize expensive services and has established good rapport with Pretoria academic to this effect. The following two services need to be succinctly discussed.

Cardio-thoracic surgery

Since the departure of the head of department, two years ago, this department has continued to provide excellent service under the leadership of two senior consultants. The department has developed expertise in the area of valves surgery in view of the epidemiological background of the population served plagued by rheumatic fever. Against this backdrop, it is our view that the department should be headed by at least a Principal specialist.

Oncology service

Although patients with various malignancies are taken care of in the hospital, there is no dedicated medical oncology service. Patients with complicated cancer are referred to PAH for further management.
Due to various constraints, PAH is not anymore in a position to unconditionally assist us in this regard. There is therefore a need to set up satellite of medical oncology at Ga-rankuwa hospital. This will require a dedicated consultant and registrar as well as earmarked budget for medicaments.

There is an outreach program to the following hospitals: Rustenburg, Polokwane-Mankweng And Oddi. In addition the department of family medicine provides service at district level in Soshanguve.

Bed Composition

Our assumption is that 30 % of beds may be classified as level one. However there are disciplines where this number could be very low. Concerning the split between the two other levels, our view is that only a well-conducted survey can determine that. Once we establish the level one hospital, all the beds will belong to family medicine.

TABLE 4 BED NUMBERS BY LEVEL OF CARE

DISCIPLINE	LEVEL 3	LEVEL 2	LEVEL 1	TOTAL
Internal Medicine	89	67	67	223
Surgery	64	67	48	160
Orthopaedics	72	53	54	179
Obstetrics*	22	54	32	108
Gynaecology	24	60	36	120
Paediatrics	70	94	70	234
Family Medicine				
ICU	20		0	20
Other			200	710
TOTAL	**361**	**856**	**507**	**1724**

Hospital efficiency

Until proper accounting system based on cost centers is fully functional or there is a physical separation of levels of service, it will be spurious to calculate any cost of bed by level of care. The only sensible calculation at this stage is average cost applying to all beds. The following is an illustration of what we saying.

As compared to last year actual expenditure of R497809 000 and in consideration of 1724 approved beds, an average cost per bed day is R 791.00. The hospital has an average length of stay of 8 days with total PDE of 502336 and cost per PDE of R991

Facility Management

According to the facilities audit conducted in 1996, Ga-rankuwa hospital needs to be replaced, as it did not meet basic requirements of a modern academic hospital. Since then a decision has made recently to build a new outpatient and emergency departments. The planning process is taking place. There are funds made available from the revitalization program to rebuild the hospital. Serious discussion will take place over the next few weeks to decide on the configuration of the future Ga-rankuwa, taking into consideration the proposed shift of beds.

The average NHFA condition grading of the hospital decreased from 4.00 in 1996 to 3.76 in 2001. (See table in programme 8).

Delegations

The chief executive has received various delegations that would assist in effective running of the hospital. However more needs to happen in order to make the hospital management fully accountable.
Appointment up to one level below the CEO can be finalized in hospital.
A fully-fledged hospital board is in place.
Through the board the hospital accounts to the public by presenting a monthly report on activities and use of resources. The board is then able to support the hospital in achieving its goals. They are currently involved in arranging the open day.

Table:. Activity indicators for the year 2001/02

	Beds	BOR (%)	LOS	Operations	Admissions	Patient days	Outpatients	Deaths
Medicine	223	86	8		6696	72384	8616	882
General Surgery	160	89	7	2316	5340	53352	13464	325
Orthopaedics	179	71	8.66	3984	4008	47616	18996	51
Paediatrics	234	66	8.5		4692	57180	13248	435
Paediatric surgery	20	67	6.5	420	756	4956	804	35
Gynaecology	120	75	8.5	1068	3924	33480	17676	72
Obstetrics	108	166	3.3	2568	18300	66948	16044	13
Neurosurgery	80	59	16	372	576	17556	1488	85

Cardio-thoracic	40	50	9	480	504	7248	16752	18
Ophtalmology	80	62	6.3	2208	2208	18480	19044	8
Casualty&Family							41736	
ENT	50	70	10	816	780	13560	530	11
ICU	22	63	12		252	5256		221
Plastic surgery	60	61	12	672	1308	14532	4032	350
Urology	54	80	9.8	1356	1632	16056	2892	35
Renal Transplant	34	46	5	22	816	3468	5868	
Psychiatry	48	41	5		972	7692	10356	10
Total	**1512**	**67.5**	**8.46**	**16848**	**52764**	**439764**	**187716**	**2551**

Table: Performance indicators for Ga-Rankuwa Hospital

Indicator	**Province wide value**
Input	
Expenditure on hospital staff as percentage of total hospital expenditure	67.3%
Expenditure on drugs for hospital use as percentage of total hospital expenditure	7.6%
Expenditure on hospital maintenance as percentage of total hospital expenditure	0.1%
Process	
Percentage of hospitals with operational hospital board	yes
Percentage of hospitals with appointed (not acting) CEO in place	yes
Percentage of hospitals with business plan agreed with provincial health department	yes
Percentage of hospitals with up to date asset register	? yes
Maximum permitted value of procurement at discretion of hospital CEO without reference to provincial level	✓
Output	
Patient fee income per separation	✓
Quality	
Percentage of hospitals in facility audit condition 4 or 5	✓
Percentage of hospitals that have conducted and published a ppatient satisfaction survey in last 12 months	?
Percentage of hospitals with designated official responsible for coordinating quality management	yes
Percentage of hospitals with clinical audit (M&M) meetings at least once a month	yes
Efficiency	
Average length of stay	8.5
Bed utilisation rate (based on useable beds)	68%
Expenditure per patient day equivalent	R991
Outcome	
Case fatality rate for surgery separations	867

5.1.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

Major Policies

Currently the hospital has 1724 approved beds of which an estimated 30% are level one and the remaining cover levels two and three. Our medium to long-term goal is to scale down the number of beds to about one thousand beds.

A process is underway to open 300 beds to accommodate level one patients. Level one has been broadly defined to include step down, short stay and day cases. A phased approach has been chosen over a big bang approach. Two wards of 40 beds each will be open by early next month, and will expand gradually. This will be within the hospital but separately managed. In line with the regional service plan this level one hospital would later be relocated outside the hospital, and be incorporated in the district health system.

We are setting up a booking system in order to reduce inappropriate referrals and allow doctors to devote sufficient time to patients. This will also streamline activities in the emergency department.

We are envisaging build a gate-keeping clinic to shield the hospital from inappropriate referrals. This should be located outside or at the frontiers of the hospital.
In the meantime an area has been identified near the casualty department, and will be used for triage and treatment of minor ailments.

Broad strategic objectives

- The vision of the hospital is "Quality care for better health"

- Our mission is Through innovative and participative leadership, the hospital pledges to

  provide quality health care services by:

  - Encouraging and fostering a culture of transparency and open communication with all stakeholders
  - Effective and efficient utilization of resources
  - Providing a clean and safe working environment
  - Improving academic excellence

Strategic objectives

- To provide cost effective care of highest standard that is responsive to the needs of communities and in line with government overall strategy
- To maximize the utilization of resources by creating appropriate financial structures that enhance accountability
- To create an environment where people are appreciated and able to develop to their full potential

5.1.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

5.1.4 DESCRIPTION OF PLANNED QUALITY IMPROVEMENT MEASURES

The establishment of quality department through the appointment of dedicated staff is a major milestone towards the institutionalization of excellence in patient care service. The team includes two quality managers at the level of assistant director, four queue managers and two help desk officers. A part of the directorate of clinical services, the quality department should influence all areas of hospital operations.
To us quality includes both the technical quality of clinical care as well as patient 's experience of hospital activities and processes. An overall strategy is being developed based on creating a patient friendly environment and the practice of safe and effective medicine. Clinicians have accepted the holding of joint and multidisciplinary morbidity and mortality meetings in addition to those held in each department. This joint meeting will investigate every occurrence of adverse clinical events in the hospital.

The quality department coordinates the accreditation committee that ensures the hospital meets the standards set by the province. There is a marked improvement in most standard. Directional signs have been placed in all key areas to indicate the location of clinics and departments.
This is complemented by a vibrant help desk that guide people and handle complaints they may have.

A complaint policy is in place to guide and standardize the management of complaints. It encourages frontline supervisors to speedily resolve complaints.
A patient satisfaction survey is being planned and waiting times measurements are regularly done as part of the provincial accreditation process.
Quality awareness days are organized to foster the caring ethos throughout the hospital.

The review of starting time of clinics and ward rounds is underway in an attempt to reduce waiting time in the pharmacy. The booking system will undoubtedly also impact on waiting times throughout the system. We are also looking at opening some satellite dispensaries for example to separate paediatric patients from adults.
An audit of the length of stay is underway to understand the reasons for prolonged stay in the hospital. The results thereof will inform policies to maximize beds utilization.

Table 8 Waiting time in various sections

	Casualty	Clerks	Outpatients	Pharmacy
Waiting time	P1: No waiting P2: 1hour P3: 2 hours	1-2 hours	1-2 hours	2-4 hours

5.1.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table: Measurable objectives and evolution of performance indicators Garankuwa hospital

Strategic Objectives	Measurable Objective	Indicator[1]	2001/02 (actual)[2]	2002/03 (estimate)[2]	2003/04 (target)	2004/05 (target)	2005/06 (target)
Strengthen community participation and maintenance of infrastructure and equipment	Establish hospital boards in the hospitals	Availability of operational hospital board established	yes	yes	yes	yes	yes
Revitalisation of hospital services	Develop a business for the hospital *(Service plan)*	Availability business plan agreed with provincial health department	yes	yes	yes	yes	Yes
Improve financial management	Ensure delegated functions to CEO of the hospitals	Maximum permitted value of procurement at discretion of hospital CEO without reference to provincial level	Data still being verified				
Improve quality of care	Conduct and publish patient satisfaction survey annually	Availability of published patient satisfaction survey in the last 12 month	#	#	no	yes	yes
	Ensure coordination of quality management in hospitals	Availability of designated official responsible for coordinating quality management	yes	yes	yes	yes	Yes

	Establish clinical audit in all hospitals	Cclinical audit (M&M meetings at least once a month	yes	yes	yes	yes	Yes
	Ensure hospital utilisation	Case fatality rate for surgery separation	867		To be determined		
Equitable distribution of resources	Ensure hospital efficiency	Expenditure on hospital staff as percentage of total hospital expenditure Expenditure on drugs for hospital use as percentage of total hospital expenditure Expenditure on hospital maintenance as percentage of total hospital expenditure Patient fee income per separation	67.3% 7.6% 0.1% Data still being verified		To be determined		

SUB PROGRAMME 5.2: PRETORIA ACADEMIC HOSPITAL

5.2.1 SITUATIONAL ANALYSIS

Pretoria Academic Hospital is one of the four Central hospitals in Gauteng Province; and is therefore also going to be affected by reduction in funding for tertiary services as funds get shifted to District Health Services. It is therefore extremely important that adequate planning is done to safeguard tertiary services provided by this institution. Strategic Planning for this hospital should also be in line with the Strategic Position Statement of the Gauteng Department of Health and the Medium Term Expenditure Framework allocations as determined by the Department.

The hospital currently has 999 approved beds but will have 789 beds when relocation to new premises happens at the beginning of year 2004. The current hospital premises consist of 75-year old buildings that are in parts still in durable condition; and are regarded as a national monument. PAH serves a population of 822 804 in the Tshwane – Metsweding Health Region; as well as most of Mpumalanga province. We also cater for large numbers of patient referrals from Limpopo and North-West provinces, some of whom are referred to us via Ga-Rankuwa Hospital.

There is currently one Regional hospital (Kalafong Hospital) within the Region, which refers patients to us; but this hospital is situated 20km away; and there is currently no other facility within 8 km of to provides a 24-hour health service. This results in PAH being flooded with large numbers of clinically inappropriate patients who desperately primary health care and Level 1 need care - and there is no where else to go for the ever growing inner city population and for people from other surrounding suburbs; especially after hours and weekends.

The new hospital, having fewer beds than the current hospital, will have to be a strictly tertiary (Level 2 and 3) hospital and be closed to walk-in off-the-street patients. This means that there is an urgent need for a decision to be made on gateway District Health Services (including a Level 1 hospital) to be established near the new PAH to protect the tertiary nature of this hospital; otherwise the hospital will be overrun by inappropriate patient demand resulting in inability to restrict cost of care to allocated budget. The current PAH buildings present an excellent opportunity and facility to house this gate keeping function.

Staff Establishment

The staff establishment of the current Pretoria Academic Hospital is as follows:

Table 1 Staff Establishments

Category	No. Employed	Vacant Posts		Cost per Annum	Cost % age per Annum	% age of Total Employees
		Funded	Not funded			
Medical Interns	34	0	0	3924212	1.09	1.01
Medical Officers	66	10	2	19542921	5.48	1.96
Registrars	126	18	0	36750281	10.23	3.75
Specialists + Senior Specialists	73	9	26	34710485	9.73	2.17
Principal & Chief Specialists	32	2	0	14439934	4.04	0.95
Nursing Assistant	360	6	48	27015824	7.57	10.72
Staff Nurses	207	10	58	18384640	5.15	6.16
Professional Nurses	214	17	197	22033473	6.17	6.37
Chief Prof. Nurses	364	0	0	50476608	1.41	10.83
Pharmacy Interns	5	0	0	476915	0.13	0.14
Pharmacists	13	4	2	2764509	0.77	0.38
Allied Health Professionals	338	48	102	5664131	1.59	10.06
Managers & Administrators	360	39	226	38629512	10.83	10.72
Directors & Chief Directors	4	0	0	1486692	0.42	0.11
Support Staff	1162	46	158	80529807	22.57	34.64
TOTAL	**3358**	**209**	**819**	**356829944**	**100.00**	**100.00**

Cross-Border Patient Flow

Because there are no facilities offering tertiary services in Mpumalanga and Limpopo provinces, Pretoria Academic Hospital is subjected to a heavy load of patients from these provinces. Cross border flow gets worsened by the fact that Ga-Rankuwa Hospital is currently not able to offer some tertiary services like radiotherapy for cancer patients, organ transplantation, medical oncology, some angiographic services and in-vitro fertilization. This means all patients from Mpumalanga, Limpopo and North-West needing these services place an extra burden on PAH over and above patients from within the Tshwane-Metsweding Health Region. Some patients originate from as far away provinces as Eastern Cape, Northern Cape and Free State (also because the N1 national road traverses Pretoria and generates a lot of emergency cases).

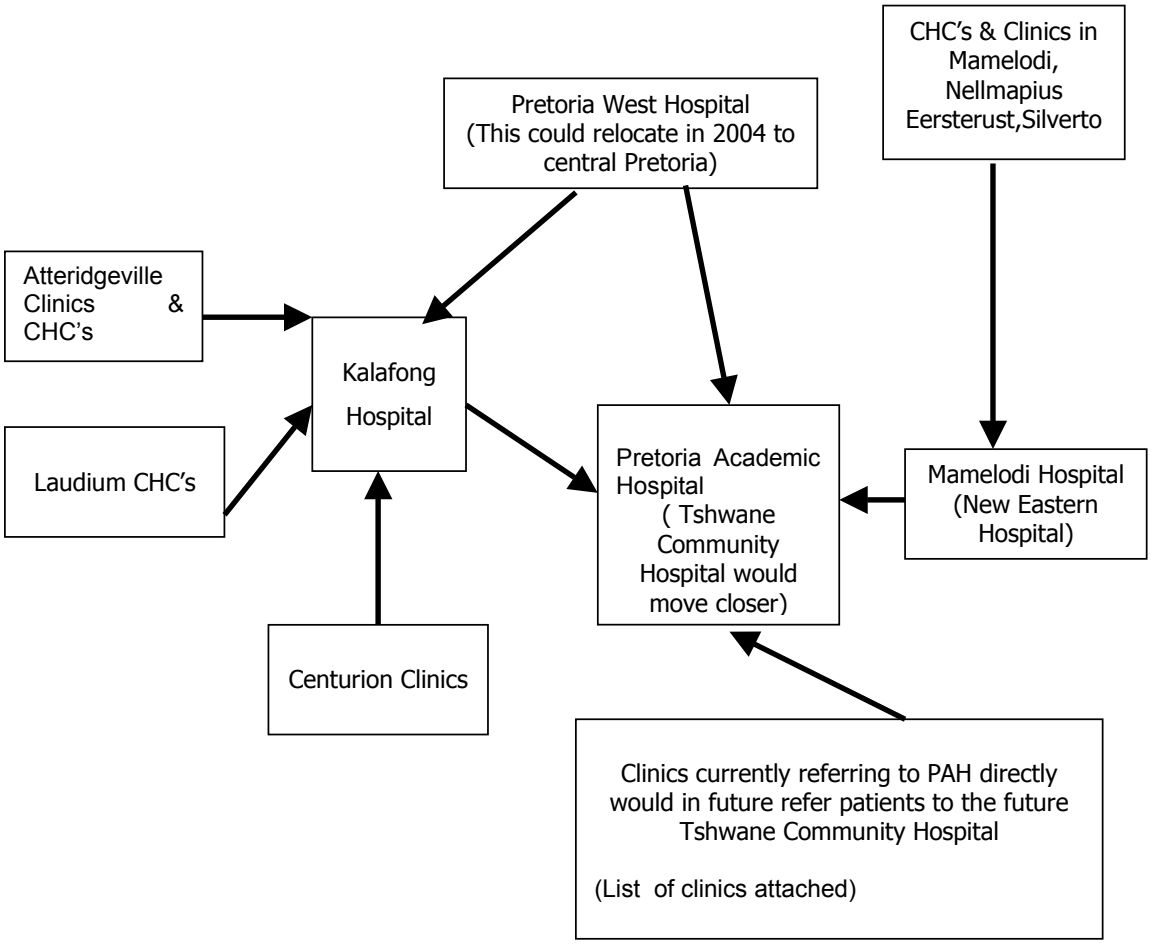
The following are totals per province since implementation of the Medicom system in August 2002(ie. three months):

.

Table 3 Cross Border Flows

Discipline	**North West**	**Limpopo**	**Mpumulanga**	**Free State**	**Other**
TOTAL	**486**	**1733**	**2490**	**118**	**286**

Referral Routes
Referral routes to and from Pretoria Academic Hospital are as indicated here:



Services Rendered.

Pretoria Academic Hospital provides a comprehensive service covering all the medical specialties as well as subspecialties like Neurosurgery, Cardiothoracic Surgery, Vascular Surgery, Reconstructive Surgery, Medical Oncology, Radio-oncology, Nuclear Medicine, Cardiology, Neurology, Nephrology and Gastro-enterology. Transplant operations are also performed except for heart transplants, which are done only at Grootte Schuur Hospital (as determined by National Health Policy).

Some inappropriate (level of care) hospital services are still provided from necessity due to the current lack of adequate lower level gateway hospitals and CHC's in the Pretoria Region.

Bed Composition

Table: Bed Numbers by Level of Care

DISCIPLINE	**LEVEL 3/4**	**LEVEL 2**	**LEVEL 1**	TOTAL
Internal Medicine	103	50	0	153
Obstetrics / Neonatal	57	25	31	113
Gynaecology	21	10	0	31
Paediatrics	40	25	0	65
General Surgery	51	30	63	144
Neurosurgery	42	0	0	42
Cardio Thoracic Surgery	45	0	0	45
ENT	9	5	14	28
Ophthalmology	10	7	5	22
Urology	15	10	9	34
Orthopaedics	40	50	32	122
ICU	52	0	0	52
HCU	24	0	0	24
Radiotherapy	25	0	0	25
Medical Oncology	22	0	0	22
Psychiatry	0	0	0	0
Family Medicine	0	0	0	0
TOTAL NUMBER OF BEDS	**556**	**212**	**154**	**922**

Facility Management

The Physical State of the hospital is outlined in programme 8.

Delegations

The Pretoria Academic is functioning under the same delegations regarding procurement, finance and human resources as all other tertiary Institutions

The Institution can deal with procurement aspects to the value of R1,000,000.00
The Institution has a constituted Hospital board, which is functional.

The board consists of 8 members from the community

Function according the prescripts dealing with Hospital Boards

The Institution implemented an asset management system (BAUD) and the system is maintained on a regular basis.

Hospital utilization

The hospital has attended a total 21563 emergency patients of which 13306 were trauma cases, 2071 , Gynaecology and 5857 Paediatrics and 1.5% of this patients died.
The hospital has a Bed occupancy Rate of 85% to 90% and Average length of stay of 6 days.
Normal deliveries/Total deliveries = 66.9%

Table : INDICATORS - ACTIVITIES 2001/2

Discipline	Beds	Admissions	Patient-days	BOR %	ALOS	Operations	Discharge/ Transfers	Deaths	Outpatient Visits
Internal Medicine	110						1,989	497	4,210
-Cardiology	12	720	3,240	75%	8		1,725	Not Available	9,610
-Nephrology (Renal Dialysis)	12	296	3,048	80%	2		522	7	4,949
-Neurology	19	548	6,468	85%	12		885	58	6,634
Obstetrics/Neonatal	113	8,994	20,630	100 %	3	843	6,712	358	9,436
Gynaecology	31	2,430	8,918	97%	8		3,030		6,457
Paediatrics	65	1,011	5,371	92%	8		5,256	14	3,591
General Surgery	144			90%	7		9,648	159	13,616
Neurosurgery	42	296	2,290	85%	13		1,287	92	2,388
Cardio Thoracic Surgery	45	303	2,437	79%	10		1,419	25	1,012
ENT	28	699	1,191	75%	3	224	1,490	2	3,425
Ophthalmology	22	1,074	4,230	95%	5		1,101	4	10,440
Urology	34			89%	6			11	
Orthopaedics	122	3,613	21,477	92%	7	3,076	3,978	44	25,955
ICU	52	1,245	7,239	100 %	12		1,408	293	
HCU	24			100 %	3				
Radiotherapy	25	246	4,853	100 %	15		666	86	9,121
Medical Oncology	22	325	1,474	100 %	12		672		11,784
Psychiatric	0								1,586
Family Medicine	0								26,155
Emergency Unit	0							254	58,439
Total	922	21,800	92,866	85%	7	4,143	41,788	2,259	208,808

Outreach Programmes

As Pretoria Academic Hospital serves as a tertiary referral hospital for Mpumalanga Province, the Surgical and Medicine departments have a continuous outreach programme to and co-operation with the Witbank Hospital. As Witbank Hospital is the main gateway hospital to that province, it is of utmost importance to empower that hospital to deal effectively with as many as possible clinical cases.

An academic outreach and clinical co-operation also exist with Jubilee Hospital in the Hammanskraal district to the north of Pretoria.

Some clinical empowerment outreach is also done to Tembisa Hospital as that hospital is in Pretoria Academic Hospital's referral system.

Close co-operation naturally exists between Pretoria Academic Hospital and Kalafong Hospital as that hospital is an integral part of the academic complex.

Table: Performance indicators for Pretoria Academic

Indicator	Province wide value	Hospital range	National target
Input			
26. Expenditure on hospital staff as percentage of total hospital expenditure	58.1%	✓	
27. Expenditure on drugs for hospital use as percentage of total hospital expenditure	13.4%	✓	
28. Expenditure on hospital maintenance as percentage of total hospital expenditure	1.6%	✓	
29. Useable beds per 1000 people*	✓		
30. Useable beds per 1000 uninsured people*	✓		
31. Hospital expenditure per person*	✓		
32. Hospital expenditure per uninsured person*	✓		
Process			
33. Percentage of hospitals with operational hospital board	yes		
34. Percentage of hospitals with appointed (not acting) CEO in place	yes		
35. Percentage of hospitals with business plan agreed with provincial health department	yes		
36. Percentage of hospitals with up to date asset register	? yes		
37. Maximum permitted value of procurement at discretion of hospital CEO without reference to provincial level	✓	✓	
Output			
38. Separations per 1000 people*	✓		
39. Separations per 1000 uninsured people*	✓		
40. Patient day equivalents per 1000 people*	✓		
41. Patient day equivalents per 1000 uninsured people*	✓		
42. Patient fee income per separation	✓	✓	
Quality			
43. Percentage of hospitals in facility audit condition 4 or 5	✓		
44. Percentage of hospitals that have conducted and published a	?		

ppatient satisfaction survey in last 12 months			
45. Percentage of hospitals with designated official responsible for coordinating quality management	yes		
46. Percentage of hospitals with clinical audit (M&M) meetings at least once a month	yes		
Efficiency			
47. Average length of stay	7.7	✓	
48. Bed utilisation rate (based on useable beds)	85%	✓	
49. Expenditure per patient day equivalent	R 1627	✓	
Outcome			
50. Case fatality rate for surgery separations	293	✓	

* Not to be filled in for individual central hospitals.

5.2.2 Policies, Priorities and broad strategic objectives

Major Policies

The Pretoria Academic Hospital Health Service Cluster was recently formed in accordance with GDH policy. The Cluster consists of PAH and all the hospitals, Community Health Centres and clinics within the referral network of PAH. Managers of all these institutions together with clinicians will meet at least monthly to:

define and refine the referral routes;
improve communication between facility managers and clinicians to facilitate problem free patient transferals;
determine, confirm and align institutional bed numbers in accordance with Regional and Provincial Service Plans;
facilitate the devolution of non-tertiary services (including Level 1 beds) to District Health Services in line with Strategic Positioning Statement;
ensure gateway primary health facilities to protect the expensive tertiary services;
facilitate development of District Health Services.

In determining bed numbers and situation of facilities, cognizance will be taken of the HIV/ADS pandemic, the effects of violence and other trauma.

Broad strategic objectives

- Refine the established referral systems
- Ensure academic teaching, training, and research support to health professionals
- Optimise highly specialized services
- Optimal utilization and management of Human Resources
- Market the hospital and promote communication
- Ensure effective management of the budget
- Maintain high quality services
- Provide effective security and logistical support services
- Support decommissioning of existing hospital

5.2.3 Analysis on constraints and measures planned to overcome them

Analysis will be provided with the final strategic plan.

5.2.4 Description of planned quality improvement measures

A **Quality Assurance Task Team** monitors and advises Hospital Management on service quality issues. The **Infection Control Unit** and in-house **Wound Care Consultant** are an integral part of the quality team.

Quality Managers were appointed to supervise and monitor all service quality aspects in the hospital on a continuous basis. **Quality champions** were appointed in all nursing areas to assist the Quality Managers in this task. The quality improvement measures and monitoring were extended to cover the night shifts as well.

A **Patient Complaints Management System** was developed and also effectively slotted into the monitoring function of the Quality Assurance Task Team.

***Please Rate Us*-boxes** were placed all over the hospital (all clinics and wards) with simple evaluation cards for patients to evaluate the quality of the services provided by the specific areas.

Follow-up **Patient Satisfaction Surveys** were conducted with the help of the Department of Marketing, Faculty for Economic Sciences of the Technikon Pretoria.

Help desks were established to assist patients and the public with enquiries. The help desks assisted by **dedicated client liaison officers** (queue managers) and **volunteer "floor walkers"** at the Outpatient Departments and the Emergency Unit, contributed largely to a marked improvement in the user-friendliness of the hospital.

A special **client liaison-training programme** was developed and presented to frontline workers like porters, security guards, registration clerks, secretaries, etc.

Client liaison and service quality was instituted as standing items on the agendas of the various **hospital sectional (floor) meetings** to constantly refocus staff on these vital aspects of their daily tasks.

A **Clinical Audit Committee** was established to start looking at the clinical quality aspects, and soon became quite popular amongst clinicians as a forum for sharing valuable clinical information and debates on best practices and protocols.

An **Accreditation Team** draft and continuously review internal hospital standards on nursing, logistical and various other processes in support of quality service rendering.

In support of the staff of the hospital, an effective **Occupational Health and Safety Unit** as well as an **Employee Assistance Programme (EAP) unit** was established.
The **cleaning teams** were reorganised and with a bit of rescheduling and better supervision the cleanliness of the hospital improved markedly.

Signage was improved where needed and within the limitation of the available budget, a **facilities renovation programme** was embarked on to improve the general public frontline facilities.

Specific **quality indicators** were identified to monitor quality performance on all fronts of service rendering in the hospital; these are monitored on a continuous basis and reported on to Hospital Management and the Hospital Board.

Pretoria Academic Hospital initiated its own internal Service Excellence Awards programme to recognise exceptional performance by individuals (per category of staff) as well as service units. Each year's winning unit is entered for the Gauteng departmental Khanyisa awards.

Table 8 Queue Waiting Times (e.g.)

EMERGENCY UNIT	**13 -22 Feb 2002**			**14 - 24 June 2002**		
	P1	**P2**	**P3**	**P1**	**P2**	**P3**
Waiting time for file	26 min	15 min	20 min	16 min	18 min	29 min
First Nurse contact	0 min	16 min	11 min	0 min	04 min	15 min
First Doctor contact	0 min	1hr 18min	1hr 28min	0 min	45 min	1hr 30min
Consultation time between Doctor & Specialist	30 min	2hrs 20min	0 min	51 min	2hrs 45min	0 min
Waiting time: Porter, bed and transport	1hr 50min	1hr 5 min	0 min	2hr 15min	1hr 59min	0 min
Total Time in Unit	**10hrs 7min**	**4hrs 20min**	**3hr 10min**	**4days 8hrs**	**5 hrs**	**3hr 30min**

Comments: P1 have a generally long period of waiting at the emergency unit. This is due to the fact that these are seriously ill patients, requiring a series of laboratory investigations and specialist attention
Files are generally made available after the patient has already been seen by either the nurse or the casualty officer.
The admission period is also lengthened by the administrative process that all admissions go through

5.2.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND EVOLUTION OF PERFORMANCE INDICATORS

Table: Measurable objectives and evolution of performance indicators Pretoria Academic hospital

Strategic Objectives	Measurable Objective	Indicator[1]	2001/02 (actual)[2]	2002/03 (estimate)[2]	2003/04 (target)	2004/05 (target)	2005/06 (target)
Strengthen community participation and maintenance of infrastructure and equipment	Establish hospital boards in the hospitals	Availability of operational hospital board established	yes	yes	yes	yes	yes
Revitalisation of hospital services	Develop a business for the hospital *(Service plan)*	Availability business plan agreed with provincial health department	yes	yes	yes	yes	Yes
Improve financial management	Ensure delegated functions to CEO of the hospitals	Maximum permitted value of procurement at discretion of hospital CEO without reference to provincial level	Data still being verified				
Improve quality of care	Conduct and publish patient satisfaction survey annually	Availability of published patient satisfaction survey in the last 12 month	#	#	yes	yes	yes
	Ensure coordination of quality management in hospitals	Availability of designated official responsible for coordinating quality management	yes	yes	yes	yes	yes
	Establish clinical audit in all hospitals	Clinical audit (M&M meetings at least once a month	yes	yes	yes	yes	yes

	Ensure hospital utilisation	Case fatality rate for surgery separation	293				
Equitable distribution of resources	Ensure hospital efficiency	Expenditure on hospital staff as percentage of total hospital expenditure Expenditure on drugs for hospital use as percentage of total hospital expenditure Expenditure on hospital maintenance as percentage of total hospital expenditure Patient fee income per separation	58.1% 13.4% 1.6% Data still being verified		Still to be determined		

5.3. SUB PROGRAMME: JOHANNESBURG HOSPITAL

5.3.1 SITUATIONAL ANALYSIS

Appraisal of existing services and performance for the past year

The Johannesburg hospital is a central academic hospital in the South of Gauteng with 1163 operational beds, offering a full range of tertiary, secondary and primary care services mainly to the population of the Central Wits Region. The hospital is located in Parktown and serves in theory as a referral hospital for a number of hospitals in its referral chain. In practice it is a "walk-in" health service for all patients in the province and from the provinces of Mpumalanga, North West and Limpopo. The Primary Care support services in the inner city area require strengthening. The period during 2002 was a difficult year, posing many complex services delivery challenges. Our management and clinical teams worked hard to maintain standards while staying within the agreed budget frames. Johannesburg Hospital primarily serves a population of 5 million from various provinces as per attached annexure.

The introduction of a new Hospital Information System, as well as getting to terms with a new accounting system created many problems with management information, making planning, monitoring and control of services and costs impossible.
During this current 2002/03 financial years we are confronted with a few unplanned issues that is taking a major toll on the budget. The most significant is the huge increase in *NHLS tariffs*. This was further compounded by the poor billing systems on the side of the NHLS *contributing to an incorrect base line* used to project hospital budgets.
Our budget for 2002/03 is R710 350 000. This constitutes a 1.4% increase on the 2001/02 budget allocation. This budget is hugely understated. It is not adjusted for the following fixed and variable costs:
The July 2002 increases in salary and the once off R850 payment
The NHLS tariffs increases of 8%
Annual price escalation for fixed term contracts - nursing, maintenance and leasing.
Annual increases with state tender items e.g. drugs, consumables equipment etc.
Increase in consumer price inflation.
Increase in-patient through put.
Exchange rate fluctuations contributing to huge price changes e.g. Radiation oncology project, CT, drugs,
Policy of "Floor patients"
Huge equipment and maintenance backlogs
Facility Management

Refer to programme 8 for other information about the grading of the hospital.

Table 7 Physical State of Institution

Area	1996 Grading	Subsequent Gradings	Major Projects (Current/Completed)	Future Projects	Financial Implications
JBH Hospital			Radiation Oncology		R 90 million
JHB Folateng			Building Alterations and Partitioning		R 5 million
Hospital Street			Building Alterations		R 2.5 million
Pharmacy projects			Building Alterations and Partitioning		R 3 million

Table 1 Staff Establishments

Category	Number Employed	Vacant Funded Posts	Vacant Not Funded	Cost per Annum	Cost as a % of Total Salary	Post as % of Total Posts
Medical Interns	40	1	0	3 195,417	0.80	0.99
Medical Officers	39	10	0	6 954 790	1.74	1.18
Registrars	171	17	23	26 683 685	6.68	4.52
Specialists + Senior Specialists	141	19	3	29 667 599	7.43	3.84
Principal & Chief Specialists	47	5	53	21 045 960	5.27	1.25
Nursing Assistants	185	0	106	7 606 830	1.91	4.44
Staff Nurses	327	0	103	17 215 078	4.31	7.86
Professional Nurses	545	0	80	38 287 612	9.59	13.09
Chief Prof. Nurses	334	0	57	32 328 528	8.10	8.02
Pharmacy Interns	5	0	0	312 840	0.08	0.12
Pharmacists	27	5	19	7 110 144	1.78	0.77
Allied Health Professionals	240	46	216	22 788 480	5.71	6.87
Managers & Administrators	16	4	1	2 828 756	0.71	0.44
Directors and Chief Directors	4	0	0	1 509 592	0.38	0.10
Support Staff	1813	121	950	181 736 637	45.52	46.47
TOTAL	3981	228	1614	399 271 948	100.00	100.00

Table 3Cross Border Flows

Discipline	North West		Limpopo		Mpumalanga		Free State		KZN		Other	
	OPD	In Pt	OPD	In Pt	OPD	In Pt	OPD	In Pt	OPD	In Pt	OPD	In Pt
Internal Medicine	2		11	2	4		1		2	1		22
Surgery	28	10	19	10	20	16	14	2	21	8		
O&G	12	5			10	3			25	7	91	97
ICU												5
Other	58		16		40		5		23	16	10	
TOTAL	**100**	**15**	**46**	**12**	**74**	**19**	**20**	**2**	**71**	**32**	**101**	**124**

Services Rendered

The Johannesburg hospital provides a full range of services; The Level 1 services are estimated at 20%, 30% at L2 and 50% at L3. The percentage of beds is indicated in the next table. Family Medicine is a Level 1 service.
All level one services will be provided as a separate cost center until the services can be physically moved and delivered on a new site.
Some highly specialized services will be highlighted because they are scarce services or special expertise exists here. Trauma is highlighted as a *high cost* service.

- Paediatric Haematology / Oncology including Thalassaemia (only service in the province) & Haemophilia.
- Cystic Fibrosis clinic.
- Child Psychiatry (Child and Adolescent unit)
- Medical Haematology / Oncology. It is envisaged that this will be the center of excellence in the province, with a new Oncology center under construction for completion mid 2003. An investment for equipment will be required in the next three financial years.

- Cardio-thoracic surgery – excluding heart transplants. Outcomes with Paediatric cardiac surgery are especially good.
- Trauma – This is the only trauma center in the country that meets the criteria for accreditation by the American Trauma Society, who set the world standard for trauma quality.
- Renal Transplant
- Gauchers Disease clinic
- Interventional Cardiology

Bed Composition

Table 4 Bed Numbers by Level of Care

Discipline	Level 3	Level 2	Level 1	Total
Internal Medicine	169	131	80	387(300)
Surgery	86	106	40	438(192)
Orthopaedics	33	27		93 (60)
Obstetrics*	30	55	20	88(85)
Gynaecology	30	17		36(47)
Paediatrics	105	85	20	132(190)
Family Medicine	0	0		0(0)
ICU	47	29		68(76)
MOU				
TOP unit				
Rehab beds				48
Other	0	0		(0)
TOTAL	**500**	**450**	**160**	**1163(950)#**

* includes beds in Labour Ward.

\# 950 beds is the proposed bed status for Johannesburg Hospital. The Red numbers indicate the current status.

In order to address the reduction of tertiary beds, as well as to improve the efficiency of use of L2 and L3 beds, there are strategies to move L1 services off site to other hospitals, along with appropriate resources. The inpatient beds will be isolated on one floor of the hospital and operate as a separate L1 facility, and the Casualty will be moved off site as we develop into a referral only facility. Only an Accident and Emergency service will remain to treat priority one emergencies.

Table: Performance indicators for Johannesburg central hospital

Indicator	Province wide value	Hospital range	National target
Input			
Expenditure on hospital staff as percentage of total hospital expenditure	53.5%	✓	
Expenditure on drugs for hospital use as percentage of total hospital expenditure	13.4%	✓	
Expenditure on hospital maintenance as percentage of total hospital expenditure	2.6%	✓	
Process			
Percentage of hospitals with operational hospital board	yes		
Percentage of hospitals with appointed (not acting) CEO in place	yes		
Percentage of hospitals with business plan agreed with provincial health department	yes		
Percentage of hospitals with up to date asset register	? yes		
Maximum permitted value of procurement at discretion of hospital CEO without reference to provincial level	✓	✓	
Output			
Patient fee income per separation	✓	✓	
Quality			
Percentage of hospitals in facility audit condition 4 or 5			
Percentage of hospitals that have conducted and published a ppatient satisfaction survey in last 12 months	?		
Percentage of hospitals with designated official responsible for coordinating quality management	yes		
Percentage of hospitals with clinical audit (M&M) meetings at least once a month	yes		
Efficiency			
Average length of stay	4.8	✓	
Bed utilisation rate (based on useable beds)	90%	✓	
Expenditure per patient day equivalent	R1927	✓	
Outcome			
Case fatality rate for surgery separations	358	✓	

✓*Data is being collected or verified*

Referral Routes

Table: The Johannesburg Hospital referral cluster consists of the following hospitals:

Regional and District Hospitals	
	Helen Joseph / Coronation Hospital
	Leratong hospital
	Tambo Memorial Hospital
	Far East Rand Hospital
	Heidelberg
	Yusuf Dadoo Hospital
	Carletonville Hospital
	Pholosong Hospital
	Germiston Hospital
	Edenvale Hospital,
	South Rand Hospital.
Psychiatric Specialist Hospitals	
	Sterkfontein Hospital
	Tara H. Moross Centre
Specialist Infectious Diseases Hospital	
	Sizwe Hospital
Other Provinces	
	North West Province
	Limpopo
	Mpumalanga
	Free State

In practice we are a "walk-in" service for all patients in the province and from other provinces. The Primary Care support services in the inner city area as well as in much of the areas covered by this cluster of hospitals require strengthening.

Delegations

Financial Delegations

- Corporate Management
- Internal control
- Financial Misconduct
- Strategic planning
- Budgeting
- Revenue Management
- Assets and Liability Management
- Management of losses and debtors

Procurement delegations

- The Chief Executive Officer can approve up to R 1 million.
- The COE has got full delegation excluding dismissal.

Human Resources delegations

- Recruitment and appointments: one level below the CEO
- Transfer between institutions
- Extention of employment beyond the age of 65
- Remunerative work outside the Public services
- Remunerated overtime
- Precautionary suspension
- Pronouncing sanctions for misconduct

5.3.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

The objectives described below will be introduced in selected disciplines across the institution. Each clinical head will be required to put together detail plans of how this will be achieved and what are the measurable outcomes.

Major policies

The policy to *rationalize tertiary care* and *reduce tertiary beds* will have significant effects on the way health care is delivered at Johannesburg Hospital.
The proposal is to have a total of 950 L2/3 beds, 500 at L2 and 450 at L3. The management of these beds, to ensure increased access to tertiary care, will *require the decision* to make central hospitals *referral only* centers, with strict referral policies including policies on *geographical* access to services available at other central or regional hospitals, as well as defining what services will be provided as a provincial competency. Implied in this shift of beds is the shift of *services* and *staff* to institutions where capacity has been increased / improved. A HR management tool will be required to manage the movement of staff.
The success of this policy will depend on the creation of adequate regional and district hospital services. The method of *communicating* this strategy to the community is vital.

Broad strategic objectives

- Improve quality and access for tertiary patients in the Gauteng and highly specialised services for the country
- Improve the use of resources in the delivery of services.
- Review and implement appropriate general management structures and systems.
- Review and strengthen clinical management systems and structures.
- Introduce clinical governance and clinical audit systems in all departments.
- Improve both clinical and management accountability across the institution.
- Reduce misuse, abuse and theft of financial and other resources.
- Implement 60 differentiated amenities beds for private patients
- Explore further areas for Public Private Interactions.
- Implement appropriate monitoring mechanisms across the institution.
- Strengthen internal and external communication.

5.3. 3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

The proposed increased of ±1.4% on the 2001/02 budget is too small. This will mean a decrease in real terms. We are proposing fairly major restructuring and realignment of services and systems requiring substantial investments in people, equipment and systems.

Even with proved efficiencies and reduced theft and wastage we cannot sustain current service levels and maintain quality. We will commit all our energies to tackling the challenges of

- Improving efficiency
- Reducing theft and wastage
- Better resource use and
- Improving revenue

We are concerned that even with these strategies to stay within the proposed budget envelope will have all or some of the following negatively implications:

- Key posts frozen
- Longer waiting lists for surgery
- Longer waiting times in clinics, casualty and pharmacy
- Reduced beds availability and increased ambulance diversions
- Quality may be compromised
- Shortages in drug availability
- Training will be adversely affected
- Further rationing of care for expensive clinical services
- Individual workloads will increase
- New services will be compromised
- Key equipment needs not further delayed or not purchased.
- Regular equipment and building maintenance will be affected

We will have to review all services offered including beds and agree what is affordably and sustainable.

What would we like to see happening?

- Increased funding for personnel to bring it more in line with an acceptable norm. At least an increase in personnel expenditure of 7.5% of 2002/03. To ensure that we are able to get key equipment needs e.g. CT, digital diagnostic equipment, monitors and MRI the budget should be increased by R 15m (2% of total expenditure).

- Any other increases will be absorbed through revenue generation, improved efficiencies and reduced theft

5.3.4 Description of planned quality improvement measures

The hospital board with seven members has been established. The primary role of the board is to advice on relevant patient issues.

A Quality Assurance team is active in the hospital, driven by a Quality Manager and Patient liaison/queue manager. Their major project over the next year will involve training of employees on quality principles and strategies, and strengthen quality programmes existing in the institution. Already an effective complaints system is functional, and patient surveys have been completed relating to waiting times in the Casualty, in the pharmacy, and also a survey on staff attitudes.

Improved quality of Care in waiting times, cleanliness, comfort, linen, complaints procedure, monitor waiting lists, theatre cancellations, guidelines/protocols, Std. Ethics committees.

Table 8 Queue Waiting Times (e.g.)

Area	Waiting Time Duration	Comments
Clerks	20 Minutes	
OPD (to see Doctor)	15 Hours	
Pharmacy	3 Hours	Too high
X-Ray	15 Minutes	Average
Total Wait	4 Hours	
Switchboard	(rings/minutes)	Monitoring

5.3.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table: Measurable objectives and evolution of performance indicators Johannesburg hospital

Strategic Objectives	Measurable Objective	Indicator[1]	2001/02 (actual)[2]	2002/03 (estimate)[2]	2003/04 (target)	2004/05 (target)	2005/06 (target)
Strengthen community participation and maintenance of infrastructure and equipment	Establish hospital boards in the hospitals	Availability of operational hospital board established	yes	yes	yes	yes	yes
Revitalisation of hospital services	Develop a business for the hospital *(Service plan)*	Availability business plan agreed with provincial health department	yes	yes	yes	yes	Yes
Improve financial management	Ensure delegated functions to CEO of the hospitals	Maximum permitted value of procurement at discretion of hospital CEO without reference to provincial level	Data still being verified				
Improve quality of care	Conduct and publish patient satisfaction survey annually	Availability of published patient satisfaction survey in the last 12 month	#	#	yes	yes	yes
	Ensure coordination of quality management in hospitals	Availability of designated official responsible for coordinating quality management	yes	yes	yes	yes	yes
	Establish clinical audit in all hospitals	Clinical audit (M&M meetings at least once a month	yes	yes	yes	yes	yes

	Ensure hospital utilisation	Case fatality rate for surgery separation	358				
Equitable distribution of resources	Ensure hospital efficiency	Expenditure on hospital staff as percentage of total hospital expenditure Expenditure on drugs for hospital use as percentage of total hospital expenditure Expenditure on hospital maintenance as percentage of total hospital expenditure Patient fee income per separation	53.1% 13.4% 2.6% Data still being verified		Still to be determined		

 # New indicator, data not available

SUB PROGRAMME 5.3: CHRIS HANI BARAGWANATH

5.3.1 SITUATIONAL ANALYSIS

Chris Hani Baragwanath Hospital is listed in the Guinness Book of Records as being the largest hospital in the world (1998)

The hospital treats 100 000 inpatients and 550 000 outpatients per year. As one of the group of academic hospitals associated with the University of the Witwatersrand, Johannesburg, we provide the bulk of undergraduate and postgraduate clinical training. We are also supportive of many research projects and a number of international research centers are situated within the hospital.

Chris Hani Baragwanath Hospital provides a wide range of tertiary medical services. Those not provided at Chris Hani Baragwanath Hospital include radiation therapy, cardiac surgery and transplantation services.

The hospital is the only public hospital directly serving the people of Soweto, which has a population in excess of 1,5 million. Our referral centers are situated in Central, Southern and Western Gauteng, but we also accept patients referred from other areas in Gauteng, other provinces and other countries. It is expected that the population of our catchment area will remain constant over the next three to five years.

We perform 45 000 operations per annum, see 350 emergency cases per day, of which an average of 9 per day are gunshot wounds.

We have approximately 521 doctors, 2145 nursing staff; and 85 professionals in Allied Disciplines.

TABLE: PRESENT STAFF ESTABLISHMENT

CATEGORY	NUMBER EMPLOYED	VACANT FUNDED POSTS	VACANT NOT FUNDED	COST PER ANNUM	COST AS A %AGE OF TOTAL SALARY	POSTS AS A %AGE OF TOTAL POSTS
Medical Interns	60	0	0	6032323	1.37%	1.13%
Medical Officers	111	22	0	19009331	4.32%	2.50%
Medical Officers Principal.	70	10	10	17367940	3.95%	1.51%
Registrars	144	5	0	28099431	6.39%	2.80%
Specialist & Senior Specialist	107	16	21	32661348	7.43%	2.32%
Principal & Chief Specialist	29	6	6	17810455	4.05%	0.66%
Nursing Assistants	870	30	294	45861419	10.43%	16.94%
Staff Nurses	150	10	98	11099833	2.52%	3.01%
Professional Nurses	260	70	440	36290682	8.25%	6.21%
Chief Professional Nurses	865	60	163	108005353	24.56%	17.41%
Pharmacy Interns	8	0	0	645701	0.15%	0.15%
Pharmacists	7	6	2	1800242	0.41%	0.24%
Allied Health Professionals	239	70	75	28955154	6.58%	5.82%
Managers & Administrators	25	4	16	7174527	1.63%	0.55%
Directors	5	0	0	2544350	0.58%	0.09%
Support Staff	1471	63	403	72206270	16.42%	28.87%
Admin Staff	488	32	164	4275576	0.97%	9.79%
Total	4909	404	1692	439839935	100.00%	100.00%

TABLE: SERVICES RENDERED:		
Medicine	*Radiology*	***Obstetrics and Gynaecology***
General Medicine	*Nuclear Medicine*	
Cardiology	*Pharmacy*	***Allied Services***
Neurology	*Orthopaedic Surgery*	Physiotherapy
Nephrology	*Surgery*	Occupational therapy
Haematology	General Surgery	Social work
Rheumatology	Trauma	Speech therapy and Audiology
Pulmonology	Palliative Care	Human Nutrition
Gastroenterology	Neurosurgery	
Infectious diseases	Otorhinolaryngology	***Medical technology***
Dermatology	Eye Hospital	
Oncology	Plastic Surgery and Burns	***Clinical Technology***
	Hand Surgery	
Psychiatry	Urology	***Medical Equipment Services***
Adult psychiatry		***Obstetrics and Gynaecology***
Paediatric psychiatry	*Emergency Services*	
Paediatrics	*Anaesthesiology*	***Allied Services***
General Paediatrics		Physiotherapy
Paediatric Haematology and Oncology	*Intensive Care*	Occupational therapy
Paediatric Cardiology	High Care	Social work
Paediatric Neurology	Intensive Care	Speech therapy and Audiology
Paediatric Nephrology	Specialized Units (Neurosurgery, Cardiology, Medicine, Burns, Neonatal)	
Paediatric Endocrinology		
Paediatric Pulmanology		
Paediatric Gastoenterology		
Neonatology		
Paediatric Surgery		
Paediatric Burns Unit		

CROSS BORDER FLOW

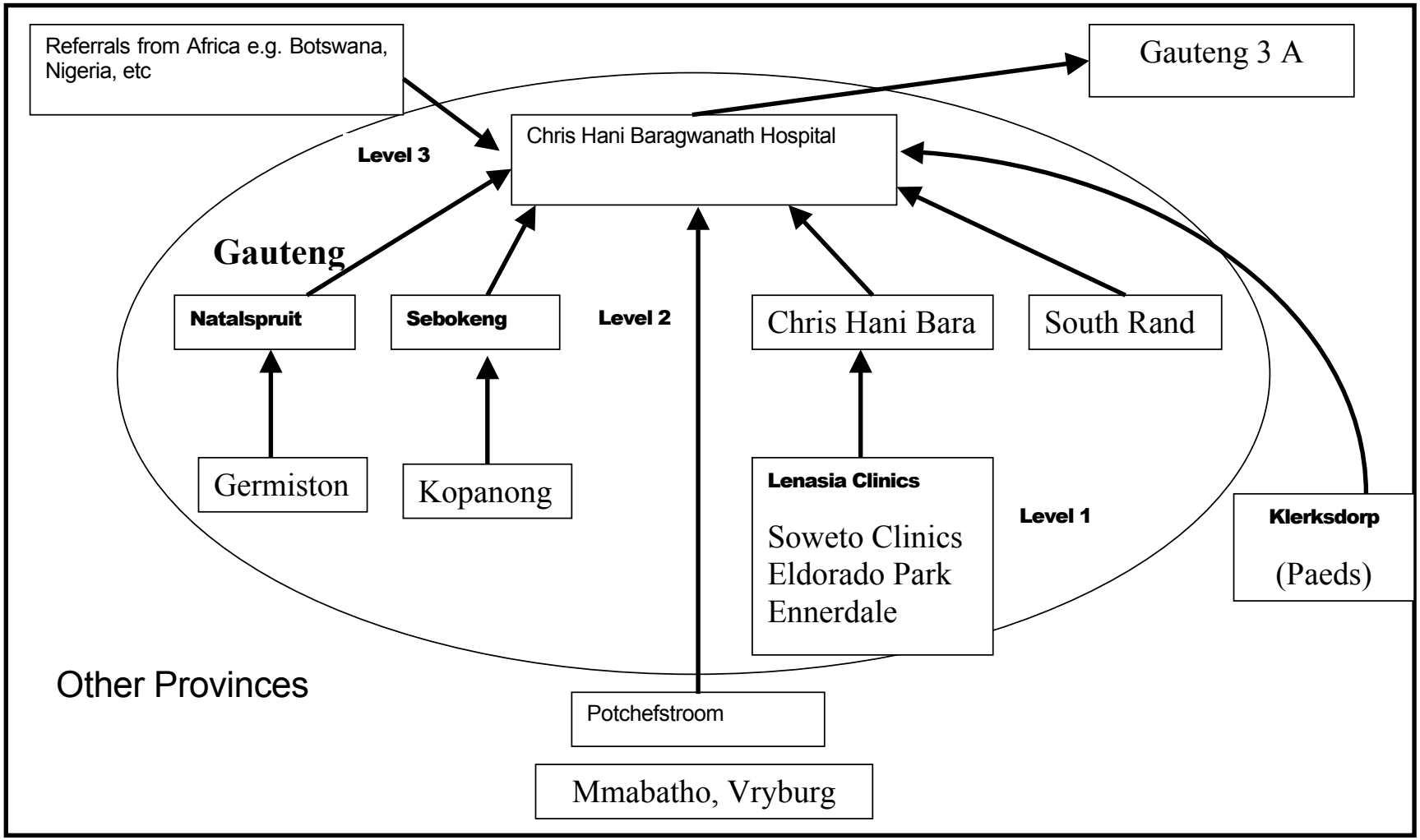
It is difficult to establish the number of cross border flow. Nevertheless it is estimated at 5% of the total patient load.

BED COMPOSITION

Discipline	Level 3	Level 2	Level 1	Total
Internal Medicine	166	417	250	833
Paeds Surgery	62	16	4	82
Orthopaedics	159	127	32	318
Surgery	157	261	105	523
Obstetrics	101	353	50	504
Gynaecology	19	67	10	96
Paediatrics	143	204	61	408
ICU/HC	12	10		22
TOTAL	819	1455	512	2786

REFERRAL ROUTES

In practice we are a "walk-in" service for all patients in the province and from other provinces. The Primary Care Support Services in the inner city area as well as in much of the area covered by this cluster of hospitals require strengthening.



Quality Management Department has been active in the hospital since the 1st of April 2002. Composing of Quality Managers and Patient Liaison Officers /Queue Managers. Their duties include monitoring waiting times and regularly measure and support managers in responding to patient satisfaction indicators.

Waiting Times
Waiting times are measured to improve accessibility of service to patients

Areas Monitored

AREA	AVERAGE WAITING TIME	COMMENTS
O.P.D	± 15 minutes	
Casualty	± 6 minutes	
Pharmacy	± 10 minutes	
Obstetrics and Gynae:		
Admin	± 5 minutes	
Ante Natal Clinic	± 1 Hour	Patient have to wait for doctors
Labour Ward	Depends on labour progress and availability of Doctors to constantly monitor	
Operating Theatre	± 5 minutes	Emergencies
	± 24 Hours	Non-urgent patients are booked

The waiting time is directly proportional to number of staff members serving the patients. The lesser the staff members e.g. Clerks, the more the waiting time. In O.P.D the infrastructural setting is not conclusive for a linear flow of patients.

Complaints Procedure
Patients can complain regarding services rendered; verbally or in writing.

Acknowledgement
Complaints are acknowledged within 24 hours of receipt.

Receipt
Upon receipt the complaint is categorized according to I, II and III.

Response
A response should be sent through to the complainant within 7 working days forwarded. Delay in responding to complaints to Heads of Departments or to individual renders the service ineffective.

Number of complaints received from April – October -8

Average number per month -13

Table: indicators - activities 2001/2 (12 months)

Discipline	Beds	Admissions	Patient days	BOR %	ALOS	Operations	Discharges / Transfers	Deaths	Outpatients Visits
Internal Medicine	739	33569	187505	67.40%	4-6		30448		126636
Cardiology	10	516	24696	80%	2-3 weeks		1932		21090
Nephrology (Renal Dialysis)	35		17108						2260
Neurology	42	1468	9816	68%	6-8		1896		24204
Obstetrics	486	19735	94672	53%	4-6	5472	23688		34572
Gynaecology	96	20298	25692	73.30%	2-3	4398	8196		
Paediatrics / Neonatal	343	9855	89912	72%	9-12		9393		57060
General Surgery	327	12500	86892	73%	6-7	4284	19092		33804
Neurosurgery	70	1372	7836	85%	5-8	642	1800		2856
Cardio Thoracic Surgery									
ENT	58	12000	30912	80%	4-6	1000	2232		7404
Ophthalmology	89	7124	3276	46.10%	3-4	4776	15000		52188
Urology	45	2200	13908	90%	6-8	600	1452		6096
Orthopaedics	318	7568	87528	75.40%	11-14	4536	5520		26664
ICU	18	1124	5556	26%	3-5		1044		
HCU	10	1680	8400	50%	3-6		1480		
Radiotherapy									
Med. Oncology/Haematology	12	676	6912	80-90%	2-3 weeks		645		
Psychiatric	155	1802	4094	86.5	28days		1656		8598
Family Medicine									
Emergency Unit (Resus)	6	3174			2 hours				
Total	**2853**	**133487**	**704715**	**95.892**		**50040**	**125474**	**7172**	**403432**

Table: Performance indicators for Chris Hani Baragwanath hospital

Indicator	Province wide value	Hospital range	National target
Input			
Expenditure on hospital staff as percentage of total hospital expenditure	52.6%	✓	
Expenditure on drugs for hospital use as percentage of total hospital expenditure	6.8%	✓	
Expenditure on hospital maintenance as percentage of total hospital expenditure	2.6%	✓	
Useable beds per 1000 people*			
Useable beds per 1000 uninsured people*			
Hospital expenditure per person*			
Hospital expenditure per uninsured person*			
Process			
Percentage of hospitals with operational hospital board	yes		
Percentage of hospitals with appointed (not acting) CEO in place	yes		
Percentage of hospitals with business plan agreed with provincial health department	yes		
Percentage of hospitals with up to date asset register	? yes		
Maximum permitted value of procurement at discretion of hospital CEO without reference to provincial level		✓	
Output			
Separations per 1000 people*			
Separations per 1000 uninsured people*			
Patient day equivalents per 1000 people*			
Patient day equivalents per 1000 uninsured people*			
Patient fee income per separation		✓	
Quality			
Percentage of hospitals in facility audit condition 4 or 5	✓		
Percentage of hospitals that have conducted and published a patient satisfaction survey in last 12 months	?		
Percentage of hospitals with designated official responsible for coordinating quality management	yes		
Percentage of hospitals with clinical audit (M&M) meetings at least once a month	yes		
Efficiency			
Average length of stay	6.1	✓	
Bed utilisation rate (based on useable beds)	6.3%	✓	
Expenditure per patient day equivalent	R1613	✓	
Outcome			
Case fatality rate for surgery separations	?	✓	

* Not to be filled in for individual central hospitals.

PHYSICAL CONDITION OF THE HOSPITAL.

The Hospital that the civilian authorities took over from the British Army in 1948 had 1450 beds housed in solidly built brick pavilion style wards. These wards still make up the bulk of the accommodation. Added later were the Maternity Hospital and the agreement with the Order of Saint John to take over the Eye Hospital, further expanded the hospitals scope. A further part of the Baragwanath make up is the addition of prefabs when accommodation crises occurred.

Pavilion Wards:
Basically the construction of these wards is sound. However, the state of repair various from modern and acceptable in newly renovated wards (1 to 8) to unfit for human habitation (Ward 13b)

Maternity Hospital:
This hospital is of sound construction and is functional. Problems here are that the passages are low and dark. This must be addressed as part of the revitalisation program. A further area that will have to be redesigned is the delivery room. The layout is not conducive to patient confidentiality and dignity. It requires a major replanting.

St John Eye Hospital:
The clinical areas are in reasonable condition, but the wards are in need of serious refurbishment. Some are old prefabs that must be replaced while the brick built wards need replanning. There is a need for a children's ward in this facility.

Prefabs:
All the prefabs must be replaced. Most are of asbestos construction and are not acceptable in terms of the Occupational Health and Safety Act. Services housed in these buildings include Physiotherapy, OT, Out Patient Department, Renal Unit, HIV Clinic, Anaesthetic Workshop, Orthopaedic Workshop, Drip Room, Offices and Radiography College.

Other Buildings:
Buildings like the Admin, College, Laboratory Block, Transport and Works Department Building are new and need maintenance only.

5.3.2 Policies, Priorities and Broad strategic objectives

Broad strategic objectives

- The mission of Chris Hani Baragwanath Hospital is to become the premier provider of tertiary medical services in the country. Chris Hani Baragwanath Hospital is dedicated to building long-term relationships with our community through the provision of services perceived by both the community and health providers to be 'high quality'. We are also committed to maintaining and enhancing a close relationship with the University of the Witwatersrand, Johannesburg, with respect to teaching and research. We will continue to build relationships with our sister hospitals and clinics in the region. Our goal is to steadily improve our physical facilities and to ensure concomitant improvements in patient care and patient satisfaction.

- We aim to achieve the highest level of patient care based on sound scientific principles, administered with empathy and insight; to train our work corps to be the best equipped and motivated to serve the sick and injured, and to maintain and defend

truth, integrity and justice for all, at all times, to the benefit of patients, staff and the community.

- As the largest public hospital Chris Hani Baragwanath Hospital's aim is to make it also the best. The hospital has several separate functions are Clinical Care, Teaching and Research

- Our emphasis in clinical care is the provision of comprehensive care based on the knowledge and expertise of our staff in both the clinical and support areas. We aim to ensure that not only do patients receive the most cost effective medical care available (within the health resources available) but that they feel that they have been well treated.

- We will support staff that is engaged in clinical research through the provision of time and facilities to assist in approved projects and will actively encourage mensuration of heath services.

- As the largest resource in the country for the training of undergraduate and post graduate students, Chris Hani Baragwanath Hospital will strive to improve the physical facilities so as to facilitate and support the requirements of the teachers. This will include the provision of suitable seminar rooms, observation facilities, lecture rooms and teaching equipment.

5.3.6 SPECIFICATION OF MEASURABLE OBJECTIVES OF PERFORMANCE INDICATORS

Table: Measurable objectives and evolution of performance indicators Chris Hani Baragwanath hospital

Strategic Objectives	Measurable Objective	Indicator[1]	2001/02 (actual)[2]	2002/03 (estimate)[2]	2003/04 (target)	2004/05 (target)	2005/06 (target)
Strengthen community participation and maintenance of infrastructure and equipment	Establish hospital boards in the hospitals	Availability of operational hospital board established	yes	yes	yes	yes	yes
Revitalisation of hospital services	Develop a business for the hospital *(Service plan)*	Availability business plan agreed with provincial health department	yes	yes	yes	yes	Yes
Improve financial management	Ensure delegated functions to CEO of the hospitals	Maximum permitted value of procurement at discretion of hospital CEO without reference to provincial level	Data still being verified				
Improve quality of care	Conduct and publish patient satisfaction survey annually	Availability of published patient satisfaction survey in the last 12 month	#	#	yes	yes	yes
	Ensure coordination of quality management in hospitals	Availability of designated official responsible for coordinating quality management	yes	yes	yes	yes	yes
	Establish clinical audit in all hospitals	Clinical audit (M&M meetings at least once a month	yes	yes	yes	yes	yes

	Ensure hospital utilisation	Case fatality rate for surgery separation	358		Still to be determined		
Equitable distribution of resources	Ensure hospital efficiency	Expenditure on hospital staff as percentage of total hospital expenditure Expenditure on drugs for hospital use as percentage of total hospital expenditure Expenditure on hospital maintenance as percentage of total hospital expenditure Patient fee income per separation	52.6% 6.8% 2.6% Data still being verified		Still to be determined		

 # New indicator, data not available

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

6.1 SITUATIONAL ANALYSIS

Policies and strategies informing human resource development in province

Health Science Training and research is geared to support the strategic plan of the Gauteng Department of Health. Its contribution is explained in relation to each of the strategic objectives below:

Maintenance of health and prevention of disease through activities such as good nutrition, immunization programmes, and health education. A major focus will be on expanding and strengthening existing programmes for maternal and child care. In this regard the IMCI programme has been incorporated into nursing curricula, and midwives and medical doctors including anaesthetists have received top-up training in terms of the prevention of maternal deaths and, more recently, the PPIPP programme to assist in the reduction of peri-natal mortality and morbidity. The number of advanced midwives trained has also been increased in an effort to provide improved maternal care.

Early detection of disease development and prevention of the spread of diseases such as the screening of those at risk for cervical and breast cancer. The women's health training has been completely revised to assist in this regard and incorporated into existing curricula. Physical and emotional support of victims of trauma and violence will receive special focus. To this effect, the number of health professionals trained in trauma and emergency care has increased and efforts are underway to utilize the services of the emergency services training division to assist other health professionals to contribute more effectively in this regard. The number of nurses trained in orthopaedic nursing has also been increased to render better quality care to victims of trauma and violence and to reduce mortality and morbidity.

Reduction of the burden of diseases of lifestyle that are tobacco related, hypertension, diabetes and trauma through health promotion, appropriate screening, and effective interventions that will enhance optimal functionality. Apart from more emphasis being placed in formal curricula on these aspects, regular multi-professional updates have been arranged on chronic diseases to assist health professionals of all types to co-operate in managing these problems and to learn from one another.

Consolidation on programmes that will limit the impact of communicable diseases, especially tuberculosis, sexually transmitted diseases and HIV/AIDS. As a result of collaboration with an NGO, the reproductive health modules of the primary health care course has been revised. In addition a workplace education programme is under development to address these issues that will ensure maximum exposure of health professionals to knowledge and information with minimum disruption to the services - a 'learn while you earn approach'.

The Gauteng Department of Health employs more than 40 000 people. Our province is the economic heartland of the country, and any developments, including those in the health sector, have major strategic significance for the country and beyond. Our responsibilities in terms of health professionals training and research also go far beyond our provincial borders as our clinical resources and expertise are needed by neighbouring provinces and SADC countries to assist with the development of their health care professionals. The Province has the second highest population in the country and has 33% of the country's health professionals, providing referral centres for people from other provinces and other parts of Africa.

Health Science and training in the Province occurs in four distinct ways. a)The Department runs four nursing colleges and one Ambulance Training College, which it finances and manages. The Programme 6 budget is used for this purpose together with the provision of bursaries. b) The Human Resource Development Directorate also liaises with the Higher Education Institutions offering health sciences for all groups of health professional. The Province supports lecturers at the universities in terms of joint appointments paid from the Programme 1 budget. c) In addition, the HRD Directorate co-ordinates and provides continuous professional development opportunities for health professionals and provides for management and skills training for the support staff and managers in the health service d) the Province runs a bursary programme to assist new and existing health professionals and support staff to gain skills to better service the health service.

The Colleges are still governed by the Hospital Ordinance No 14 of 1958. While working within the provincial regulations and policies, the colleges have:
provincial policies all aspects of the college's functioning such as selection of school leavers, and selection of employees of the Department, academic progress and termination of training, regulations exist for the programmes offered at the colleges, which stipulate requirements for the entry to, progress in and completion of the programme.
agreements exist between each of the four Universities in Gauteng which assist the four colleges and the Gauteng health Department.
In addition the nursing students are contracted to serve the province on completion of training.

There are two categories of nursing student viz those on fully paid study leave from their employers and those who are employed in a temporary capacity as student nurses for the duration of their training.

- Higher Education of health professionals in the universities and technikons is provided for within the national framework for example:
- The Higher Education Act (Act No 101 of 1997)
- The Skills Development Act (No 97 of 1998)
- The South African Qualifications Authority Act (Act No 58 of 1995)
- The Nursing Act (Act No 50 of 1978) as amended by No 5 of 1995 and No 19 of 1997.

Training needs assessment and gap analysis; consultation process used to inform the needs assessment

At present, six universities, four nursing colleges and four technikons are making use of the clinical facilities provided by the Gauteng Department of Health as shown in table 1 below. In addition, an increasing number of private educational providers are requesting permission to use these facilities. The staff of the provincial services, which, due to financial restrictions are reduced in number and are already hard pressed to provide adequate service to the patients, does the majority of the clinical supervision. Training institutions are being increasingly pressurized to take responsibility for this aspect of teaching themselves. Training institutions are, however, also experiencing financial difficulties – the provision of additional staff for clinical supervision would be a serious problem for them.

Table 1 – Institutions of Higher Education making use of Clinical Facilities of the Gauteng Department of Health

Higher Education Institution	Categories of Health Personnel Using facilities
University of the Witwatersrand	Medical, Nursing, Occupational Therapy, Speech therapy, pharmacy, social work, dental, clinical psychologists and physiotherapy students
University of Pretoria	Medical, Nursing, Occupational Therapy, Speech therapy, Radiography, dietetics, physiotherapy, clinical psychologists and dental and oral hygiene students
Rand Afrikaans University	Nursing, social work & optometry students.
Potchefstroom University	Dietetics
UNISA	Social Work
Medical University of South Africa	Medical, Nursing, Clinical psychologist, Occupational Therapy, Radiography, dietetics, physiotherapy, pharmacy and dental & oral hygiene, speech & language audiology students
Witwatersrand Technikon	Primary Health Care & occupational Nursing, radiography, and podiatry students, clinical technologists, environmental health, emergency medical care, optometry, homeopathy, chiropractics.
Pretoria Technikon	Nursing, dental technology, paramedics, medical orthotists, prosthetists environmental health, pharmacy, sports science.
Technikon RSA	Pharmacology and nursing.
Northern Gauteng Technikon (Soshanguve)	Nursing, occupational therapy assistants, occupational health, environmental health.

Higher Education Institution	Categories of Health Personnel Using facilities
Ambulance Colleges	Ambulance personnel
Four Nursing Colleges	Nursing students – basic and post-basic
Private Colleges	Pharmacy assistants, Nursing.

The attrition rates of trained health personnel have increased from approximately 5% two years ago to 9% in the last two years. An unknown number have resigned to go overseas and to the private sector. The province has had difficulty in recruiting new graduates for several years. The advent of the extended programme for community service will assist in this regard. The effect of the AIDS epidemic is being felt but it is difficult to assess its effect on attrition rates. Higher education institutions are finding it increasingly difficult to attract new students with appropriate entry qualifications. The rate of HIV positive health personnel students appears to be increasing which will inevitably impact on the number who serves the country

as trained staff in the future. Nursing Colleges, which traditionally attracted an above average number of applicants due to the salaries paid to students, report a decrease of more than 30% in the number of applications. The higher education institutions are attempting to increase the number of first year students accepted but clearly experience difficulties in doing this. On the positive side, new opportunities are opening up for more appropriate training of health personnel such as community based education and outcomes based education as well as for mid-level health workers. Community based education is particularly resource-intensive and therefore has resulted in a significant increase in the costs of training. It has however meant that many communities that did not previously have easy access to care now have clinics staffed primarily by students on their doorsteps.

Both service institutions and education institutions share the burden of trying to maintain or improve the quality and quantity of education of health personnel. Without mutual co-operation and financial support in these difficult times, this task will not be possible.

There are approximately 4410 medical students, 5400 nursing students, 280 ambulance personnel students, 730 dental students, 130 dental therapy students, 60 oral hygiene students and 2000 allied medical students registered at the higher education institutions and colleges utilizing the provincial clinical learning facilities in Gauteng at present. The time the students spent in the institutions and the amount of supervision and materials used varies not only between professions but also between levels of training and differs for part- and full-time students. An unknown number of students are now registered on distance learning courses with higher education institutions in Gauteng, which means that they may fulfill their clinical practical requirements in other provinces. The institutions are currently being requested to give more detailed information in this regard.

Table 2 indicates the current number of health professionals enrolled at higher education institutions for 2002.

Table 2 - Total number of students in 2002 in all Higher Education Institutions

CATEGORY	RAU	U.P.	WITS	MEDUNSA	COLL-EGES	TECHRSA	PTATECH	WITSTECH	TOTAL
Medical : undergrad		1239	1382	1698					4409
Nursing: Professional (Basic)	139	120	41	187	1300	228	49	0	2064
Nursing: (Post-basic) Degree	218	120	43	59	0	0	0	0	440
Nursing: (Post basic certificate and diploma)	707	679	51	0	602	69	40	56	2207
Nursing: sub-prof					740				740
Dental: dentists		280	184	265					729
Oral hygienists		43		16					59
Dental therapists				59					59
Dental technician							71		71
Ambulance personnel					156			124	280
Medical orthotists & prosthetists							61		61

Dieticians		78		63					141
Occupational therapists		148	142	119					409
Speech therapists		179							179
Radiographers (diag)		63		51			94	145	353
Radiographer (therap)		6							6
Pharmacists			229						229
Pharmacy assistants					94				94
Physiotherapists		188	263	121					572
Clinical psychologists		9							?9
Clinical technologists							73		73
Biomedical technology							164	214	378
Optometry								120	120
Social work (undergrad)		202							202
Social work (postgrad)		287							287
Environmental health							231	168	399
TOTAL									14 570+

The Province monitors the numbers of students in the Universities and Technikons but, with the exception of basic nursing programme students, has no control over the number of students registered at these institutions, as the institutions are autonomous. They receive per capita subsidies from the National Department of Education. In addition these institutions do not train for the Gauteng Province only. There is no guarantee that students at Gauteng Universities and Technikons will even work in this province on completion of training unless contracted in terms of bursary obligations. In the case of the Nursing Colleges the students are selected from Gauteng and are contracted to work at least 2 years for Gauteng on completion. It is therefore possible to calculate needs and plan more accurately for this group. Ambulance students come from both the private and the public sector, the latter including local authorities and provincial departments. None of these students are contracted to the Province. One of the difficulties in this regard is that the HR planning has not been completed for service provision in the province. Planning has therefore been based on attrition, which may not be sufficiently accurate as the incorrect assumption is that the service needs will remain the same as they have been for the last 10 years.

At the time of restructuring the nursing colleges in 1996, it was estimated that the province needed 2800 diploma students and 600-degree students in training in order to qualify sufficient nurses for the provinces needs. This took into consideration attrition from the course due to failure and voluntary termination. Since then the effect of AIDS is beginning to be felt and the migration to other countries has increased. It has been impossible to accurately determine the effect of either of these significant factors.

The numbers of students currently enrolled at the colleges does not meet the planned numbers due to a shortage of lecturers and the fact that funding is not available to fill all students posts. Accordingly there is currently a gap of more than 1400 nursing students in training, which translates into a shortage of 350 per annum, even without considering the issues of increased migration and AIDS.

Numbers and types of institutions for health professional education in province, including institutions of higher learning for basic, post-basic and post-graduate programmes (full time, part time or distance learning); main categories of personnel trained.

This information is included in the tables above.

While these institutions are situated in Gauteng, they are national assets training health care professionals for the whole country. Students at these institutions use the facilities of the Gauteng Department of Health for their training but thereafter may, and do, work all over the country in their intern and community service years, and thereafter wherever they choose.

Appraisal of training programmes during past year (including numbers trained by main category and attrition rates by year of courses)

In terms of the nursing colleges, their student numbers and attrition rates were as follows in the 2001 academic year:

Programme	Number of students registered	% attrition (all reasons)
First Year of 4 year programme	306	24.2
2nd year of 4 year programme	328	12.2
3rd year of 4 year programme	336	27.4
4th year of 4 year programme	327	0.3
Diploma Midwifery	133	6.0
Diploma Psychiatric Nursing	22	0
Pupil enrolled nursing course	143	4.2
Primary Health Care	162	0
Theatre Nursing	67	3.0
Critical Care	70	5.7
Child Nursing	19	10.5
Palliative Care	8	0
Oncology Nursing	14	0
Ophthalmology Nursing	12	0
Orthopaedic Nursing	17	0
Advanced Midwifery	67	3.0

The Ambulance College numbers and attrition rate is as follows:

Programme	Number of students registered	% attrition (all reasons)
Basic Ambulance Assistant	56	46.4%
Ambulance Emergency Assistant	59	44.1%
Critical Care Assistant	17	29.4%

The attrition rates from the Universities and Technikons is not known but will be included in the report from next year as they have been asked to provide this information. The attrition rate from educational programmes has remained more or less constant over the last few years. The Nursing College attrition rate, although high, compares favourably with other Higher Education Institutions. The failure rate at the Ambulance College is of concern and is partly attributable to the less than satisfactory selection system in place in that the college has little control over the standard and level of the recruits. Attrition at the colleges occurs as a result of academic failure, voluntary termination in order to change career path and other personal reasons and illness. Students who pass at least one year of training at the Nursing Colleges can be enrolled as nursing auxiliaries and are therefore not lost to the health services.

There are insufficient numbers being trained to keep up with the attrition rate of health professionals from the services. This situation will inevitably deteriorate unless additional students are trained and health professionals retained in the services. Attempts are being made to train more lower categories of staff in line with the recommendations of the National Department of Health to change the ratio of 1 health professional to 1 mid-level worker to 1 health professional to 2 mid-level workers.

Main areas of health research, including health systems research

Research occurs primarily at the Higher Education Institutions and notably at the Universities. The Gauteng Provincial Research Committee is attempting to encourage a more focussed approach to research based on actual identified needs and national priorities. There has been some improvement in the liaison with Universities who are including members of staff from the Province on their research committees. Most of the bursaries granted from the Programme 6 budget are for courses leading to qualifications rather than for research. It has been noted that there is limited research in clinical areas of practice. The majority of research is to do with management and education and is not benefiting patient care. It has also been noted that there is a trend to conduct research, which leads to recommendations for clinical practice, education and management, but little is done and little money spent on implementing the research.

Key challenges over the strategic plan period

- The recruitment and quality education of sufficient health care professionals especially nurses, including specialist nurses, and emergency personnel for the health care needs of the province in the face of migration, AIDS and the reduction in the number of suitable lecturers and managers.
- Matching and amending the curricula to meet the changing health care priorities and changing educational requirements.

- The remaining uncertainty as to whether nursing colleges are to be governed by the National Department of Education.
- The need to prepare health professionals to work within a district health system while not losing the capacity to care for patients in curative facilities.
- The need to provide opportunities for continuing professional development in the face of increasing shortages in patient care areas.

6.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

The Gauteng Department of Health has three overall strategic goals viz. improving the health status of the population of Gauteng, improving health services, and securing better value for money and effective organization. The latter strategic goal embraces the strategic priority to **"ensure appropriate high quality tertiary training"**. Whereas this is the priority that gives rise to the administration of bursaries, the maintenance of the nursing and ambulance colleges, that are financed through Programme 6 on the budget, health science training supports other strategic objectives by means of providing the health professionals with skills that enable them to contribute strategic priorities such as the strengthening of primary health care, ensuring rapid and effective emergency care, and improving child health. The programmes that run within all the higher education institutions are geared to contribute to health care, as is the selection of bursary holders as the bursaries are given to those who are following courses relevant to the strategic priorities of the department.

While universities and technikons also contribute significantly to the development of the health professionals the province has no direct influence on their academic activities but seeks to cooperate to achieve the strategic aims of the health department. This section will therefore concentrates on nurse and ambulance training and bursary provision.

Broad strategic objectives

- Provide the service platform for high quality tertiary training
- Implement the skills development Act
- Management training and special projects
- Strengthen Primary Health Care training and mid level worker training programmes
- Implement bursary programme for the department

Strengthening of Primary Health Care Training

While attempts to prepare all students qualifying as health professionals to work competently in a primary health care service, it is recognized that their role will be limited until gaining further experience in the clinical assessment, treatment and care of patients presenting with health care problems. Post basic or post graduate training will therefore continue to give health professionals these skills. In order to improve access to training and train as many health professionals as possible in as short a time as possible, flexible programmes have been developed. These include part time courses, full time courses and a modular approach to training to allow health professionals to do parts of the course most relevant to their work situation. Regular update courses will be planned for nurses already practicing primary health care to keep them up to date, as well as encouraging self development and commitment to life long learning. Standardized orientation programmes will be developed to assist newly qualified staff to adapt as quickly as possible to the primary health care services.

The Higher Education Institutions have made a concerted effort to introduce community based programmes early in the training of health care professionals in an attempt to positively influence the attitudes of young health professionals and encourage a preventive and promotive approach to health care. Difficulties have been experienced due to the high cost of decentralized supervision and the difficulty of ensuring that preceptors provide quality supervision in the face of increasing demands on their time due to the staff shortages. Limited placements are available in the community while the district health system is still evolving. Academics with sufficient district health experience are also few and far between at this stage.

In order to prepare for the devolution of primary health care to the local authorities, the province has included local authority staff members in some of the continuing professional development opportunities, notably in IMCI, midwifery and mental health care training. Local Councilors have also been trained with regard to their responsibilities towards the development and support of Primary Health Care.

Strengthening of Mid-level worker training

Due to the increasing shortage of health care professionals available to the service and the National Department's recommendation to have a ratio of 1 professional to 2 mid-level workers, multiple entry and exit programmes have been developed to assist students to attain recognized qualifications at whichever level they terminate training and to recommence when they desire to. Consultation is occurring with the Higher Education Institutions with regard to improving access to the science based programmes such as physiotherapy and occupational therapy, and to provide for a co-ordinated approach to career pathing within the guidelines of the SAQA Act. A learnership is being developed to assist employees to obtain the necessary knowledge and skills to enter the multiple entry and exit programmes. This will assist the many mid-level workers who have received no formal training but have been appointed as mid-level workers by virtue of the fact that they have been assisting health care professionals for a long time.

Skills Development, management training and special projects

Skills development and other training programmes e.g. in management, counseling, home based care, ABET, learnerships are most important in contributing to the strategic objectives. There has been a concerted attempt to increase the relevance of management training and to offer training to front line managers as well as middle and senior level managers. Computer literacy training remains a popular and important activity, which needs to be supported by institutional managers to ensure that skills are practiced once back in the workplace before they are lost. Integrated management of childhood illnesses training has been incorporated into the regular nurse training programmes but some additional training is offered to upgrade nurses already practicing in the field of primary health care who did not received the benefit of this training during their own training programmes. A programme has also been introduced to upgrade the skills of primary health care nurses in terms of mental health care.

There has been a great deal of development of structured in-service education/continuing professional development programmes in the department with an entire system having been developed. The programme enables staff members to obtain some of their required CPD hours to retain registration in on duty time at the expense of the department, while still retaining a personal responsibility to acquire the remaining hours. The programme concentrates on clinical skills and updates on new approaches to clinical management of health priorities.

The Nursing Colleges in Gauteng have been the forerunners of ensuring the programmes are up to date with SA Qualifications Authority requirements and were the first to introduce outcomes based curricula. As such the curricula are competency based and are designed to meet the health care needs of the communities in South Africa with some bias towards urban health problems. While a problem solving approach is used as one educational strategy, a truly problem based curriculum has not been found to be appropriate. Increasing emphasis is being given to community based learning while attempting not to lose sight of the increasing necessity to prepare nurses to care for sick people both in hospital and at home due to the AIDS epidemic.

The Human Resource Development Directorate has been instrumental in developing the workplace AIDS programme to assist staff members at all levels to cope with the epidemic.

Implementation of bursary programme

A bursary policy has been implemented with the aim of providing financial assistance in a fair and equitable manner to employees and prospective employees of the department in order to increase the knowledge and skills available to the department in designated fields, and, in so doing to:

- redress race and gender inequities and provide financial assistance to those economically disadvantaged persons with insufficient disposable income to support their own studies and therefore would not otherwise be able to enter the health professions.
- act as a recruitment strategy to meet the demand for skilled persons in designated areas of the health service
- act as an incentive and retention strategy for existing employees with skills, knowledge and experience.
- assist in the development of career paths for employees of the Department thus retaining a skilled dedicated workforce.

The principles upon which this policy are based are on the principles of the Employment Equity Act, the Skills Development Act, the Batho Pele principles, the South African Qualifications Authority Act, the Public Service Act, the goals of transformation of the Public Service and the strategic goals and imperatives of the Gauteng Department of Health.

The policy has been developed in order to assure a good return on investment in human capital, value for money, and will amongst other things, assist economically disadvantaged persons to access higher education institutions.

An amount of R10 million has been allocated per annum for the purpose of granting bursaries based on these principles. It has been distributed in such a way that it allows for the maintenance of existing bursaries and the allocation of new ones.

6.3. ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Finance

At present student nurses are employed in a temporary post and paid a salary for the duration of their course. While the overall cost of the package at level 3 is R58 064 per annum, the student receives a net salary of R 36 405. While acknowledging that the salary is a strong incentive to come nursing and that the student nurses give a fair amount of patient care during their training, the cost of the package to the province is disproportionally large for the amount

of service received from the student during their training. Other health science students, with the exception of student radiographers, do not receive the same benefit. As stated above, there is an urgent need to increase the number of student nurses, but the amount of money available is limited. It is therefore proposed to start student nurses on bursaries rather than salaries. This will enable the province to reach their quota of 2800 student nurses, provided the staff can be found to teach them.

The College Councils are enabled in terms of the agreements between the Universities and the Province to have a fund which is administered in a similar way to those of the hospital boards. The students all pay nominal fees to the college councils, which has enabled the colleges to provide educational resources not otherwise available and have distinguished the colleges in Gauteng from those in other provinces.

A major financial constraint to reaching objectives with regard to community based education and primary health care training is the lack of finance to provide transport. While it is beneficial to the patient that health care is delivered close to them, the obvious consequence is that the health professionals need to travel to the patients. The same applies to the colleges who need to send lecturers to assist with clinical supervision. Chris Hani Baragwanath College for example, has students placed at 46 different health care facilities.

Education is a labour intensive industry and hence the proportion of funding spent on personnel is large. Chris Hani Baragwanath College uses 91.7% of their budget on personnel. While other higher education institutions have attempted to reduce the amount spent on personnel by introducing distance learning, the strength of the college system is that the students receive clinical supervision in what is a very practical field. It is therefore not possible to reduce this amount without seriously jeopardizing the quality of training.

The cost of training Ambulance Personnel is disproportionally high considering the length of the course of students and the current outputs. This is largely due to the small numbers possible at present as the college is being restructured and is short of staff that has to transfer between employers, and the large overheads e.g. equipment, vehicles and staff to run such training. It is currently estimated that the 7 week basic ambulance course costs R13 888 per student, the 16 week ambulance emergency assistant course costs R31 744 per student, and the 40 week Critical Care Assistant course costs R79 360 per student.

An attempt has been made to calculate the cost of health professional training. While the Province finances the Colleges directly and is therefore better able to monitor costs, the costs to the province of training students from the other higher education institutions are large due to the additional personnel required for clinical supervision, additional equipment etc. Each of these aspects has been taken into account below.

Estimated costs of training per category

The costing below represents the contribution that made from the provincial budgets during the 2002/2003 budget year. The universities where, most of the medical training is conducted also receive a per capita subsidy from the National Department of Education.

Nurse Training

Table 3.1. Basic Nurse Training:

The costs reflected below indicate the costs per student per year:

Cost Item	Explanation	Cost per student in R's
Cost of tuition	Tuition provided by nursing colleges who are financed by the province.	12800
Student salaries	Based on average student package	58064
Personnel supervision	From staff employed by hospitals & clinics at 5 hrs per week at R58 per hour	7656
Additional consumables	Additional cost of equipment for training purposes	660
Transport	Additional costs to hospitals and clinics	275
Subsidized accommodation	For the student nurses who live in residence	1650
University agreements	In order to offer the 4 year course colleges must have an agreement with a university.	262
TOTAL		81367

i.e. it costs approximately R81367 to train one basic student nurse per year.

Table 3.2. Post-Basic Nursing Students

The costs reflected below indicate the costs per student per year:

Cost Item	Explanation	Cost per student in R's
Cost of tuition	Tuition provided by nursing colleges who are financed by the province.	12613
COST OF STUDY LEAVE	For period not active in clinical area (3 months)	38319
Personnel supervision	From staff employed by hospitals & clinics at 2 hrs per week at R58 per hour	3480
Additional consumables	Additional cost of equipment for training purposes	330
Transport	Additional costs to hospitals and clinics	165
TOTAL		54907

i.e. it costs approximately R54907 to train one post basic student nurse per year.

Table 3.3. Medical Training

Cost Item	Cost per student in R's
Personnel	79199
Stores used for training	15950
Equipment used for training	21450
Laboratory Services for training	27500
TOTAL	144099

i.e. it costs approximately R144 099 train one medical student per year.

Table 3.4. Ambulance personnel training

Cost item	Cost per student in R's
Student salary packages	38462
Cost of tuition (budget of ambulance college)	3850
Personnel supervision	6336
Equipment	1650
Consumables	1870
TOTAL	52168

i.e. it costs approximately R52 168 to train one ambulance personnel student per year. An average of the different categories of training has been calculated.

Table 3.5. Dental Students

Cost contributor	**Present cost**
Training under-graduate dentists	209 800
Training dental therapists	104 940
Training oral hygienists	10 000

Table 3.6. Support Health Professionals

Cost contributor	**Cost per student**
Medical Orthotists & prosthetists	R81 785
Dieticians	R16 108
Occupational Therapists	R16 610
Social workers	R 8 800
Speech therapists	R9 000
Radiographers	R56 150
Pharmacists	R94 620
Pharmacy Assistants	R9 385
Physiotherapists	R12 650
Clinical psychologists	R96 987
Clinical technologists	R30 570

Table: Total costs for health personnel training

Category of Student	Cost per student (R's)	Number of students	Total cost of training (R's)
Basic Nurses	81367	2804	228153068
Post Basic Nurses	54907	2647	145338829
Medical Students	144099	4409	635332491
Ambulance personnel	52168	280	14607040
Under graduate dentists	209800	729	152944200
Dental therapy students	104940	130	13642200
Oral hygienists	10000	59	590000
Med. orthotists & prosthet.	81785	61	4988885
Dieticians	16108	141	2271228
Occupational therapists	16610	409	6793490
Social workers	8800	202	1777600
Speech therapists	18260	179	3268540
Radiographers	56150	359	20157850
Pharmacists	94620	229	21667980
Pharmacy assistants	9385	94	882190
Physiotherapists	12650	572	7235800
Clinical Psychologists	96987	?9	872883
Clinical techn &biomed	30570	451	13787070
TOTAL			1274311344

The total amount needed for health personnel training and research for the 2002/2003 financial year is **r1 274 311 344**

Calculation of expenditure

The costs reflected in the tables above reflect the cost to the Province in terms of training health care students. The most significant cost for all professional groups is that of personnel. This has been costed out by estimating the time that trained health care personnel are engaged in supervision and are not therefore carrying out their normal full time clinical role. It is recognized that in many instances, patient care and student supervision take place simultaneously, however, the time taken to treat a patient is longer as a result of teaching that occurs. In the case of some of the larger groups such as nurses, full time clinical teaching staff members are often employed for the sole purpose of student education. The Province is currently involved in a process of establishing norms for student supervision, which will allow for the setting of acceptable standards of clinical teaching as well as assisting in the costing process.
In the case of student nurses and student radiographers, they are currently employed for the specific purpose of training. This is a costly practice and also discriminates against other groups of health professional students who do not receive such a privilege. The Province is continuing to lobby for a bursary system for all categories of health care students.

The Province also pays 50% of the salaries of many university staff members who are employed to teach health care personnel in a system known as joint appointments. This is done on the assumption that health care personnel such as medical specialists render a service to the province whilst simultaneously teaching students.

Another cost contributor is stores and disposable medical equipment as well as laboratory costs. This has been calculated on the assumption that medical students and interns order more tests than do their more experienced colleagues, and that they may need to repeat procedures and tests in the process of gaining competencies.

Ambulance training and nurse training are the responsibility of the province that finance the two types of colleges.

A new initiative is the training of pharmacy assistants whose training has been out-sourced at the Province's expense, but who will do their practical work in the provincial pharmacies. They too will therefore need the supervision of the provincial pharmacists. Co-ordinators have also been appointed to supervise the project.

It is not possible at present to calculate the exact cost to specific institutions as the students are rotated through several institutions and the amount of time they spend and the number of students at any one time varies. It is hoped to develop a system of calculating a unit cost per day of training the various categories of student in which case it will be possible to more accurately calculate costs per institution and therefore to compensate the specific institutions in a more accurate manner.

The bursary system is currently also under review to ensure that all categories of health personnel are treated in an equitable manner in terms of access to bursaries in fields of study that will benefit the services.

Another significant cost is that of transport. Although students are largely expected to transport themselves to clinical sites, the teaching and specialist staff requires transport. As an attempt is made to do more community based teaching this cost is rising significantly. The new system of government transport payments and the increasing fuel costs have placed further burdens on the Province in this regard. In addition it is sometimes necessary to transport students to places that are inaccessible by public transport or unsafe.

It is still too early to accurately assess the costs of compulsory community service to the Province. It is complicated in that the Province benefits from the services of the new graduates whilst having to spend staff time assisting them and paying for additional equipment etc. Attempts are being made to develop a costing mechanism.

There is a noticeable, if yet small, trend for the private sector to utilize provincial clinical training sites. In terms of private/public partnerships this is an important, but as yet uncosted development.

Some items such as subsidized accommodation and bursaries cannot be allocated specifically to one group. Miscellaneous expenditure refers mainly to the stabilization fund requirements based on the personnel salaries.

Personnel

Personnel and financial challenges are closely related as explained above. Additional challenges to the strategic plan is the fact that lecturers have joined the migration race and it is very difficult to replace them as the health services are already short and the specialists who are needed by the colleges have left the country. These shortages provide a serious challenge to meeting targets for student numbers. It is imperative that additional incentives are introduced for nurse lecturers and managers. It has been proposed that at the very least nurse

lecturers should be put on the third notch of the Chief Professional Nurse scale and given sabbatical leave. These actions will, inevitably also have financial consequences.

Another area of concern is that the average age of the nurse lecturers is increasing as the younger ones have not been recruited due to their reluctance to join the colleges and due to migration. The shortage is most acute in specialty areas such as psychiatric nursing, critical care, theatre, midwifery and child care. The shortage in these areas threatens the attempts of the Department to improve the health status of the population and to improve health services. This further strengthens the argument that incentives will have to be paid to nurse lecturers.

Organization and management

College managers will need a great deal of additional support to manage their colleges in terms of the rapid educational changes that are occurring and the increased demands on them in terms of strategic and financial management. The student nurse posts have been moved over to the colleges to ensure that they are not eroded by the hospitals filling them with nursing auxiliaries and enrolled nurses. This has put a further challenge on the organization and management of the college who will need to employ additional administrative staff to assist with the administration of these posts.

The transport difficulties have been mentioned above and can only be addressed if further financial resources are made available.

Physical infrastructure.

Apart from one college needing additional space, the structural facilities are adequate due to the careful selection of facilities during restructuring. Maintenance work is proceeding at all four colleges in order to keep them structurally sound, safe and comfortable.

6.4 . DESCRIPTION OF PLANNED QUALITY IMPROVEMENT MEASURES

This aspect is one of the strengths of the colleges with an internal quality audit system being rolled out at present. Standards, criteria and indicators have been developed for all aspects of the colleges functioning including structure, processes and results. Internal surveyors are currently being trained who will also act as resource persons for quality improvement.

6.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

These are found on the next page in the required table. The difficulty remains that not all aspects of health science training and research are currently funded from the programme 6 budget as many aspects of the functioning of the higher education institutions are outside the control of the department. This is due to the fact that they are national assets and that they are autonomous institutions with their own strategic agendas

6.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table: Measurable objectives and evolution of performance indicators

Strategic Objectives	Measurable objectives	Indicator[1]	2001/02 (Actual)[2]	2002/03 (estimate)[2]	2003/04 (target)	2004/05 (target)	2005/06 (target)
Ensure appropriate high quality tertiary training	Implement the revised curriculum	Percentage implementation of the revised curriculum	-	-	90	100	100
Ensure appropriate high quality tertiary training	Increase number Ambulance personnel with life support training	Percentage of locally based staff with intermediate life support training	46.6	45	45	40	32
		Percentage of locally based staff with intermediate life support training	46.1	50	50	55	60
		Percentage of locally based staff with advanced support training	7.34	5	5	5	8
		Percentage of deviation of demographic and gender profile of students relative to Gauteng	55	50	45	40	35

Ensure appropriate high quality tertiary training	Train Health sciences graduates	Number of nursing students all years. Number of nursing graduates. Cost nursing graduate	4602 2558 R50 594	4602 2558 R555 244	4728 3171 R59588*	4728 3488 R63 461	4966 3836 R67 014
	Recruit sufficient school leavers with the capacity to successfully complete nurse training and ambulance training programmes	Number of new Recruits % of required recruits		413 87.8%	1. 730	2. 750	3. 770
	Prepare nurses to participate actively in the district health services and curative services	% first year entrants who graduate from the course % of graduates employed in district facilities % of graduates employed in hospitals facilities Number of nurses trained in speciality areas		61.1% 17.6% 77% 630	65% 20% 75% 700	67% 25% 75% 750	70% 25% 75% 750
	Provide bursaries to staff members	Number of new beneficiaries	404		500	550	600

	Increase the number of mid-level workers trained in the province.	Number of mid level workers trained		4. 150	5. 200	6. 250	7. 250

6.6 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Table: Evolution of expenditure by budget programme and sub-programme in current prices (R million)[1]

Sub-programme	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)	2004'05 (MTEF projection)	2005/06 (MTEF projection)
1.Nurse training colleges	41,641	79,814	98,152	122,400	153,000	160,000
2. EMS training colleges	2,148	1,267	4,000	4,350	4,500	4,750
3.Bursaries	1,544	2,078	10,000	10,000	10,000	10,000
4. Training other	394	11,261	16,100	17,350	19,268	20,000
Total programme	45,727	97,420	128,252	153,965	186,633	194,615

Note: The nursing colleges are taking over the student nurse posts from the hospitals in a phased manner, ending in 2003/2004, hence the apparent increase in the budgets.

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

7.1 SITUATION ANALYSIS

Linen Supply

During the past year there has been a marked improvement in the supply of linen in the province. Significant progress has been demonstrated in the management of linen, both soiled and clean, at all hospitals, which has contributed to qualify of care and service to the patients.

Medical Supplies Depot

The Medical Supplies Depot has continued to supply an excellent warehousing and distribution service for pharmaceuticals and surgical sundries in the past year. This Depot provides a shared supply chain to all healthcare institutions in Gauteng.

The average service level for the year was 91.22%. The target service level for the year was 93,7%. The 91,22% shows that 91.22 of every 100 orders placed by institutions were supplied complete on the first request during this year. This service level is within reasonable limits.

The shrinkage in the Depot in the financial year was 0.08% against 0.05% in the last financial year and 0.09% in the 1999/ 2000 financial year. This has largely been achieved by improved dispatch and delivery systems. In addition extensive well-managed security systems have assisted in this success. The figure for shrinkage for the year remains well below the 0,2% target level.

The Depot has maintained a high service level in the past year, although slightly lower than the previous financial year. The management of stock at the Depot has proved to be particular successful in keeping shrinkage within reasonable limits.

The service targets have been met consistently over the past three years and the **challenges** remains, to sustains and improve these targets in general delivery schedules and service levels.

7.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

Policies

Medical Supply Depot

This Depot was established in 1992 as a Trading Account to serve the area covered by the previous Transvaal province. It was originally established in terms of Guidelines issued by State Treasury for the purpose of providing medicines, surgical sundries and other items to hospitals and Health Care Institutions in a larger area. The Depot now services only Health Institutions in Gauteng. The MEDLOG manual provides the guideline for operation of the Store in line with the requirements of National Treasury.

Broad strategic objectives

Aligned with the strategic goals of the department, ensuring effective and efficient systems for procurement and management of assets and consumables remains a major focus during the MTEF period.

Medical Supply Depot

- The mission of the Depot the provision of an efficient procurement, warehousing and distribution system for pharmaceuticals and related medical items which are required on a regular basis by Health Care institutions and to ensure that the quality of these good meets the required standards for care.
- Efficient supply of pharmaceuticals and surgical sundries to health care institutions in Gauteng.
- Improvement of the stockholding at the Depot through capital of the Department

Line supply

Revitalisation of laundries in the province

Priorities

- Decentralisation of linen management to all hospitals
  The control over linen at ward level and the full implementation of linen banks at hospitals are expected to improved the general supply and control of linen
- The Pre-pack Store at the Depot will be fully operational during the 2003/2004 year. This will ensure that many pharmaceuticals, with high theft potential; at hospitals and clinics will be further protected b y this intervention.
- The full implementation of bar-cording, related to stock movement, in 2003 will greatly assist in improving accuracy of stock management as well as enable efficient execution stock counts at the Depot

7.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

The management of the stock at the warehouse relies on tight security system and vigilant controls over receipt and issue of stock. Random stock checks are carried out on a regular basis and full stock counts are undertaken twice a year. Shrinkage is carefully monitored and the real challenges are to continue to limit these looses in the Depot. Although the shrinkage figures compare favorable with similar warehousing situations in the private sector, continued reduction of this is a specific target.

The successful supplies of critically needed good rely on the efficient and appropriate management of stock at the Depot and the distribution to healthcare institutions.

8. DESCRIPTION OF PLANNED QUALITY IMPROVEMENT MEASURES

Description will be presented with the final strategic plan

7.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table: Measurable objectives and evolution of performance indicators

Strategic Objective	Objective	Indicator[1]	2001/02 (actual)[2]	2002/03 (estimate)[2]	2003/04 (target)	2004/05 (target)	2005/06 (target)
Ensure effective and efficient systems for procurement and management of assets and consumables	Decentralise linen management in all hospitals	Percentage ownership by hospitals	-	40	100	100	100
	Implement a comprehensive linen inventory register	Percentage of hospitals with an inventory register	-	-	80	100	100
	Improved management and administration of laundries	Number of laundries function as trading entities	0	0	2	4	4
	Reduce number of institutions with reported problems with clean linen	Percentage of institutions experiencing problems with linen supplies	2	2	1	0	0
	Ensure efficient supply of pharmaceuticals and surgical sundries	Percentage orders supplied to institutions on first request	-	-	93.5	94	94
	Improve security over stock	Percentage of assets bar-coded	-	-	60	100	100
	Establish centralised Pre-Pack Unit	% Operational	0	10%	30%	55%	100%

7.6 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Table: Evolution of expenditure by budget programme and sub-programme in current prices (R million)[1]

Sub-programme	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)	2004'05 (MTEF projection)	2005/06 (MTEF projection)
1.Laundies	59,695	70,919	63,219	77,981	84,000	89,000
2. Food Supply Services	11,664	12,647	19,681	13,380	14,200	15,000
3. Medicine Trading Account			1		1	1
Total programme	71,359	83,566	82,901	91,361	98,201	104,001

PROGRAMME 8: HEALTH FACILITY MANAGEMENT

1.5 SITUATION ANALYSIS

The Department of Health has a total of 486 Primary health facilities and 31 hospitals. Official Houses forms part of the Health Estate. It is envisaged that 40% of the houses will be sold during 2003/4 and another 40% during 2004/5. The remaining 20% will be used for Interns and Foreign Doctors.

General Condition of Health Facilities

Condition based assessments involved carefully structured appraisals of the condition and maintenance requirements of all building elements and site service groups using specially designed data collection forms were completed on all the Hospitals, CHC's, Laundries, Nursing Colleges and Mortuaries.

The assessments were limited to evaluations of the fixed asset maintenance needs through inspections of the physical conditions of the physical conditions of the fixed assets by specialist maintenance assessment teams comprising of structural, civil, electrical and mechanical engineers and quantity surveyors. The field audit teams were trained in condition assessment techniques and calibrated prior to the field work, and used a uniform condition assessment rating system, as indicated in the annexure of strategic plan format, to ensure consistency of the data collected. The target is to restore all facilities to a level 4 within the next 2 years, before proceeding to level 5 in the following 2 years.

Based on the condition assessment ratings as indicated in the annexure of strategic plan format, the average condition of the Gauteng Health Facilities is 3.83. This may be misleading and it should be noted that the condition assessment only deals with average conditions of facilities and there are individual buildings and services that are in a worse condition than indicated.
A more detailed report is available for all facilities. Table 2 below gives a summary of the condition assessment findings.

Table 2: Summary of condition assessment finding.

ELEMENT / INSTALLATION	**AVERAGE CONDITION**	**BEST FACILITY (on average) : Khutsong CHC**	**WORST FACILTIY (on average) : Meadowlands CHC**	**WORST**	
				Condition	**Facility**
TOTAL FACILITIES	3.83	4.57	3.44	3.44	Meadowlands CHC
BUILDING OVERALL	3.83	4.67	3.51	3.51	Meadowlands CHC
Building Fabric	3.81	4.85	3.45	3.45	Meadowlands CHC
Building Electrical	3.86	4.00	3.97	3.56	Sterkfontein

					Hospital
Building Mechanical	3.86	3.61	3.93	2.54	Diepkloof CHC
Site overall	3.79	4.30	3.19	3.19	Meadowlands CHC
Site Civil	3.75	4.49	3.04	3.04	Meadowlands CHC
Site Electrical	3.87	4.00	4.00	2.75	Leratong Hospital
Site Mechanical	4.00			4.00	Various

Most of the buildings require minor repairs, but painting, roofs and ceilings, in general, required attention. This has been done very successfully through the Facility Management Units and the decentralisation of "Day-to-Day" maintenance to the Institutions. In general the electrical and mechanical installations are in an above average condition but the quality and frequency of maintenance work is a major cause of concern. The worst average condition is that of the site civil works and gardens, and this contributes to the perception that the facilities are in a state of neglect.

There is a general perception that the condition of facilities are worse than indicated in the Audits and the reason could be that the need for day-to-day hygiene-type cleaning is mistakenly confused with the need for maintenance. A dirty building does not necessarily need maintenance of repairs.

Maintenance Budget:

The Estimated Replacement Cost of the Gauteng Health Facilities portfolio, amounts to R5,3 billion and the total construction area is about 2 million m².
The average Estimate Current Construction Cost, which is used to compare the maintenance needs of different ages and technology on an equitable basis, amount to about R2,650 per square meter. This is less than the Estimated Replacement Cost of the facilities of R3,500 to R4,000 per square meter, which is the cost of replacing the existing facilities with new layouts/designs and technology, and estimated between R7 to 8 billion.
The estimated current annual maintenance budget required for Gauteng Health Facilities amounts to R286,391,505, including R128,409,107 for backlog maintenance. This amounts to 5.44% of the Estimated Current Replacement Cost. Based on the assumptions that the existing maintenance backlog will be eradicated over a three-year period and a 7,5% escalation of cost per annum, the estimated annual maintenance budget for the next three years is as follows:

Table : Maintenance Backlog

Maintenance type	Year 1		Year 2	Year 3	Year 4
Planned Maintenance	131,648,400	83%	141,522,030	152,136,182	163,546,396
Preventative Maintenance	78,429,044	50%	84,311,223	90,634,564	97,432,157
Statutory Maintenance	33,612,094	21%	36,133,002	38,842,977	41,756,200
Condition Based Maintenance	19,607,261	12%	21,077,806	22,658,641	24,358,039

Unplanned Maintenance	26,333,998	17%	28,309,048	30,432,226	24,358,039
Routine and Breakdown Maintenance	20,481,998	13%	22,018,148	23,669,509	25,444,723
Incidence Maintenance	5,852,000	4%	6,290,899	6,762,717	7,269,921
Total estimated annual maintenance budget	157,982,398	100%	48,153,415	54,172,592	
Total estimated current maintenance budget	**157,982,398**	**100%**	**217,984,493**	**236,741,000**	**196,261,039**

The level or urgency for the identified maintenance work has been prioritised and a fully prioritised schedule of elements/installations has been included in each facility report. These priorities only provide for technical consideration and do not provide for sociological and political considerations.

Table 4: Physical condition of hospital network

Level of Care	Region	Name of Institution	Average NHFA condition grading and follow-up provincial audit grading (with date)					Outline of major rehabilitation projects since last audit
			1996	1998	2001	Current replacement cost	Annual maintenance budget required to address backlog over 4 years	
All Facilities					3.83	5,266,799,577	286,391,505	Add laundries and nursing colleges
Central/Tertiary	A	Chris Hani Baragwanath	3.53	3.52	3.91	617,633,669	32,507,113	Upgrading of several wards, maternity, Toilet blocks, Renal Dialysis, Storm water, Steam reticulation
	A	Johannesburg	3.73	3.60	4.00	928,322,348	34,949,835	Oncology and Wits Dental School, Upgrading of Chillers, Boiler house, Electrical reticulation, Wards, Theatre, Lifts, Various painting
	C	Garankuwa	4.00	3.61	3.76	323,199,320	22,305,693	Rehabilitation of roofs, rehabilitation of Doctors Quarters, Steam reticulation, toilets, wards, access for disabled
	C	Pretoria Academic		Not done	Not done			Wards, Entrance
Regional	A	Coronation	3.60	3.62	3.84	170,346,049	10,718,245	Various wards, boilers, water reticulation, access for disabled, extension of mortuary
	A	Edenvale	3.45	4.08	3.84	98,746,105	4,705,763	Entrance, toilets, New Boiler house, new mortuary, Laundry Equipment
	A	Helen Joseph	3.55	3.74	3.86	405,524,000	27,110,988	Upgrade wards, access for disabled,

								entrance, civil work (roads and water reticulation) several painting, replace floors, upgrade mortuary, upgrade entrance and painting of hospital.
	A	Leratong	4.04	4.12	3.91	165,750,069	9,077,434	Replace roofs, upgrade wards, replace fence, rehabilitation of water tower, upgrade kitchen, psychiatric ward
	A	Yusuf Dadoo	3.78	3.92	3.73	96,067,975	7,472,939	Rehabilitation of Ward 8, various areas, painting, replace fence
	B	Tambo Memorial	3.90	3.90	3.94	149,079,852	7,739,465	Replace fence, extension of mortuary, replace water reticulation, paint several areas including wards, burns unit, lifts
	B	Far East Rand	3.62	3.80	3.82	89,831,965	5,674,729	Rehabilitation of several roofs, outside shutters, floors, painting of wards/walls/outside, access for disabled, entrance,
	B	Natalspuit	3.69	3.92	3.95	148,211,436	6,597,855	Paint outside, replace floors, rehabilitation of roofs, lifts, sinkhole, electrical
	B	Pholosong	4.13	3.93	3.79	85,135,219	5,607,514	Rehabilitation of outside and wards
	B	Tembisa	3.76	3.84	3.94	109,956,430	5,194,121	Water reticulation, all wards, psychiatric ward, access for disabled and entrance
	B	Sebokeng	3.82	3.91	3.98	118,339,709	3,351,713	Water reticulation, wards
	B	Kopanong	3.77	4.05	3.87	112,750,793	6,411,886	Kitchen equipment, security, mortuary
	C	Kalafong	4.10	3.71	3.91	337,929,439	16,064,424	Wards, Access for disabled, entrance, walkways
District	A	South Rand	3.88	3.88	3.88	117,470,446	5,906,635	Wards
	A	Carletonville	4.30	3.78	3.92	103,725,389	4,881,463	Wards, water reticulation
	B	Heidelberg	3.61	3.84	4.07	24,522,000	1,183,850	Wards, water reticulation, waiting

								areas
	B	Germiston	3.69	3.76	3.88	87,594,918	5,112,238	Painting, emergency exit, roofs, lifts
	C	Mamelodi	3.93	4.12	3.93	21,793,019	1,247,791	Mortuary, water reticulation, toilets
	C	Pretoria West	3.85	3.86	3.87	125,019,346	7,958,009	Several wards, access for disabled, lifts
Specialised	A	Sizwe Tropical Diseases	3.58	3.83	3.81	59,450,609	2,967,544	Wards, started with Air-conditioning, new kitchen, mortuary, steam line, upgrading of electricity
	A	Tara H Moross Centre	3.87	3.71	3.95	41,819,089	1,750,196	Kitchen, roofs, water reticulation
	A	Sterkfontein	3.75	3.70	3.79	174,774,262	11,201,180	Roofs, painting, access control, fibre optic cable
	C	Weskoppies	3.46	3.70	3.69	184,078,724	15,759,303	Rehabilitation of several wards, electricity, access for disabled, fire prevention
	C	Cullinan Rehab Centre	3.79	3.82	3.90	65,657,000	3,480,718	Upgrading of wards, roofs, several areas, access control, Ventilation
Nursing College	C	Garankuwa Nursing College						
	C	S.G. Lourens Nursing College			3.50	59,542,826	7,130,817	Upgrade lifts, paint several areas
	A	Ann Latsky Nursing College			4.02	34,706,074	1,164,669	Paint several areas
	A	Baragwanath Nursing College						Paint several areas,
Community Health Centres	A	Chiawelo CHC	4.00		3.69	25,069,000	2,135,129	
	A	Diepkloof CHC	3.82		3.94	5,813,600	217,337	General renovations including floors, and painting

	A	Discoverers CHC	3.43		3.85	40,910,483	2,084,017	
	B	Etwatwa CHC	4.58		4.04	4,358,965	143,946	
	A	Hillbrow CHC	Not done					
	B	Johan Heyns CHC	3.43		3.84	42,462,000	2,722,560	
	A	Khutsong CHC	4.69		4.57	2,840,900	64,225	
	A	Koos Beukes CHC	4.01		3.96	14,251,000	603,893	
	A	Lenasia CHC	3.87		4.02	30,005,675	1,099,722	
	C	Laudium CHC	3.95		3.83	28,145,806	1,823,494	
	A	Meadowlands CHC	2.90		3.44	4,533,213	544,087	
	A	Mofolo CHC	4.47		4.04	13,036,938	444,369	
	B	Nokuthela Ngwenya CHC	3.41		3.79	24,363,449	1,475,391	Fence, Painting internal and external
	C	Stanza Bopape CHC						
	C	Soshanguve CHC 111	4.31		3.82	5,318.948	350,690	Rehabilitation inside clinic
	A	Tladi CHC	2.51		3.73	4,999,000	421,706	
	A	Zola CHC	3.92		3.75	32,816,127	2,824,765	
Laundries	A	Chris Hani Baragwanath						
	A	Edenvale						
	A	Johannesburg			3.69	60,309,735	4,476,012	66% of the cost is mechanical cost (equipment)
	C	Garankuwa						
	B	Dun Swart			3.27	116,868,954	22,078,064	75% is equipment cost/mechanical
	C	Masakhane			3.69	121,454,439	8,895,190	
Cook freeze	C	Masakhane Cook freeze						

Ambulance Training College	C	Lebone College					300,000	
Regional Offices							2,000,000	

Transfer of Government Mortuaries to the Province:

It is anticipated that Gauteng Health will take over the Government Mortuaries on 1 April 2004. To ensure that adequate provision has been made for maintenance for these facilities a Condition Based Assessment has been done resulting in the following information that will be included in the budget from 2004/5.
(Table 5)

Table 5: Condition of Government Mortuaries.

Level of Care	**Region**	**Name of Institution**	**Average NHFA condition grading and follow-up provincial audit grading (with date)**					**Outline of major rehabilitation projects since last audit**
			1996	**1998**	**2001**	**Current replacement cost**	**Annual maintenance budget required to address backlog over 4 years**	
Government Mortuaries		Diepkloof Mortuary			3.59	3,459,246	264,713	
		Springs Mortuary			3.67	2,445,544	252,532	
		Vanderbijl Park			4.11	545,174	22,988	
		Germiston			3.82	6,991,266	401,180	
		Sebokeng			3.45	3,413,751	407,253	
		Medunsa			3.84	1,783,417	93,606	
		Bronkhorst-spruit			3.48	624,172	131,792	
		Carltonville			3.48	1,051,510	167,163	
		Heidelberg			3.72	523,738	32,775	
		Roodepoort			3.68	4,167,467	311,985	
		Pretoria			4.30	12,144,952	381,506	
		Johannesburg			5	10,000,000	200,000	The current Johannesburg Mortuary is being replace as part of the rejuvenation of the Constitutional Hill and is a Blue IQ project. It is anticipated that this mortuary will

								be completed during 2003/4.
Total					**3.84**	**47,150,237**	**2,667,493**	

PERFORMANCE APPRAISAL OF FACILITIES

Accommodation Management is the management of space, the operational side of buildings, the primary installations and all the site facilities.

Asset Register

The asset register has been developed and should comply to the following criteria:
all buildings, plant, equipment and components must be assigned a unique identification number. This aspect is of particular importance, as a computerised facility management tool (PREMIS) cannot be over emphasised.

Maintenance plans (using the PREMIS programme) includes schedules, usually in tabulated form, which set out realistic action plans (in terms of time) for the anticipated regular repair, maintenance and sustained enhancement of the Institution to prolong economically useful lives of the building and to ensure their desirability. These schedules indicates:

- outstanding, current and anticipated future maintenance work;
- the action required, e.g. re-paint internal corridors;
- specifications related to the work to be done;
- estimated expenditure relative to each item of work, i.e.
- the present value costs or escalated amounts (where the
- escalation is calculated as an assumed percentage.)

8.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

Facility Management Policies

The mission of the Facility Management Section of the Department of Health is:

Facility Management aims to promote the Health of the people by the provision of well-maintained facilities in the interest of Quality Health Care.

We provide appropriate Facilities in order to:

Ensure an excellent climate for the users of services through more "friendly" facilities in terms of their appearance and design.
Create mechanisms for accountability amongst stakeholders.
Accelerate development of new facilities and upgrading of old facilities particularly for primary level care.

Meet the Health Care needs of the people.
Provide a positive working environment for staff.
Ensure appropriate utilisation of public funds.
Intersectoral collaboration within the Province**.**

The planning and provision of Facilities should reflect the needs of the services, promote the well being of patients and staff and should contribute to social and economic developments of the people of the Province.

Values and Principles

The provision of Facilities and the maintenance undertaken should provide for the cost-effective utilisation of these facilities in the interest of Health Care.

The allocation and utilisation of funds for the repair, maintenance, upgrade and construction of buildings should ensure that the Department receives value-for-money in all aspects of the provision of Health Care Facilities.

The Department relies of the following values and principles:

Equity

Facilities should be provided on equitable basis to all, should redress any existing inequities and place a particular focus on the areas where the needs of the poor would be best addressed.

Access

Appropriate levels of Health Care Facilities should be accessible to all, given the geographical, financial and other constraints.

Quality

Health Facilities should provide a quality structure and the necessary maintenance programmes to ensure the provision of Health Care Services.

Client Convenience

The Facilities should be convenient for the client in a way, which is conducive to the health and well being, and which would provide the necessary level of care.

Cost-effective

By allocating a horticulturist to a group of hospitals and clinics, this structure intends to create capacity to improve the quality of horticulture and pest control and rectify problems regarding maintenance of the terrain, gardens and Pest Control. The policy on Horticulture and Pest control intends to maximize co-operation between Institution Management, Facility Management Units (F.M.U.'s), Horticulturists and other stakeholders.Seven institutions in the province have trained Horticulturist on their staff establishment:

The objectives of the policy is to:

- To design gardens with simplicity, thereby ensuring low maintenance costs;
- Landscape attractive gardens for the beneficiaries of Health Institutions, by using a minimum of 80% indigenous plant material;
- Protecting and improving the aesthetic quality of Health Institutions by preventingindiscreet changes to the terrain of hospitals and clinics which disfeatureand harm the environment; and to implement the Conservation of Agriculture Resource Act (Act No. 43. of 1983) and amended on March 30, 2001), designating 198 invader plants (weeds). The weeds are divided into three categories.

Broad strategic Objectives

- Construction, refurbishment, revitalisation /rehabilitation and maintenance of infrastructure and equipment
- Implement capital investment strategy (CAPEX)
- Strengthen facility Management units (FMU) at institutions
- Expand Zivuseni project to implement beautification projects at the health facilities
- Implementation of Departmental service plan
-

A) HEALTH FACILITY MANAGEMENT: CAPITAL INVESTMENT, MAINTENANCE AND ASSET MANAGEMENT PLAN

A long term facilities plan has been developed for the total facilities requirements and is based upon approved strategic business objectives as well as current forecast of a major Capital and Maintenance program. The probable impact of aspects like AIDS has also been considered.
The plan for long-range facilities planning included:

The forecasting process consisted of four steps:
- gather and record past data;
- develop of trends and relationships based on past data;
- projection of trends and relationships into the future to determine basis for facilities requirements; and
- adjustment of projections for changes in requests, technology, structure, etc. to establish a forecast.

The forecast is based on the best information available and should make reasonable sense relative to past data, projections and future changes.

Several sources of funds have become available for the financing of facilities in Gauteng. While by far the largest portion of funds emanate from the budget allocated by the Provincial Treasury, some funds have been allocated by the National Department of Health and some from donor funding. Although a large amount is available, the funding still remains insufficient to institute appropriate preventative maintenance programmes.

The allocation of H R & R funds (now called Revitalisation Funds) has improved that state of facilities in Gauteng over the period 1997 to 2002.
The allocation of funds for the establishment of preventative maintenance programmes will ensure that longer-term improvements to the facilities are sustained.

8.3 ANALYSIS OF CONTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Key constraints:

- Lack or no communication with internal and external clients.
- No control over the quality of work from Public Works.
- No control over the delivery time of the service.
- No input in the budget allocation to Institutions and on the budget provided per Institution.
- Lack of concrete and verified financial and project data from GAUTRANS.
- Vandalism and theft.
- Lack of planning guide for Architects.
- Lack of updated cost norms.
- Lack of capacity in preparing briefs to GAUTRANS.

Measures to overcome constraints

- Procedure regarding decentralisation of functions to Institutions. Policy / guidelines on Planning procedures.
- Establishment of Facility Management Unit at each Institutions.
- Budget for each Institution and mechanisms to monitor expenditure
- Partial decentralised Day-to-Day budget to Institutions and Regions.
- Regular monthly meeting with Institutions, Regions and the Department of Public Transport and Works.
- Service Level Agreement with the Department of Public Transport and Works.
- Regular communication between the HOD's of the two Departments concerned.
- Acquisition of the PREMIS programme.
- CAPEX database programme can produce reports per Institution and per Region.

8.4 DESCRIPTION OF PLANNED QUALITY IMPROVEMENT MEASURES

Measuring effectiveness in decentralisation

The only way to measure effectiveness in decentralisation is by:

- Productivity (potential gains in productivity);
- Performance (potential performance improvements);
- Work Quality; and Priority.

The condition of facilities influences workflow, work methods and the ability of staff to care or patients in the most appropriate and efficient manner. Complaints in respect of care have identified facilities in poor repair, areas dirty and terrain untidy and poorly maintained

Customer satisfaction is very important and the only way to meet that is to ensure quality service and education to use the facility effectively. The Institutions would surely prefer performance (time and quality) and durability above anything else.
It is important to obtain the needs of the user and to meet their expectations within the budgetary constraints.

Customer feedback is an aspect that should receive attention, as an effective feedback programme is necessary to discover problems, determine priorities and to identity needs. At present it is not present in the current structure leading to severe discomfort for both Public Works and Health Institutions. The implementation of a HELP LINE in the Facility Management Unit has ensured that complaints are accepted, analysed and feedback is given.
Facility Management should not be seen as a quick fix to these problems but should be seen as a way to manage people to do business.
The establishment of a central Call Centre within Health is a priority for 2003/4.

Employment generated by projects:

A large number of the tenders are awarded to labour-intensive projects, Small, Medium and Micro Enterprises (SMME) and Previous Disadvantaged Individuals (PDI) contractors. In this way a large number of jobs are created. The day-to-day projects at Institutions are fairly small and many contractors from the surrounding areas are requested to quote for work. The quality of the work is relatively good and the support for the community encourages a sense of ownership in their community Institution.

B) CAPITAL INVESTMENT STRATEGY

BACKGROUND.

The rate of urbanisation in Gauteng continues to be high. Some municipal suburbs in the metropolis have increased significantly resulting in a growth in demand for residential services (including clinics) far outstripping the available financial resources. The health of an urban community is largely determined (amongst other factors) by the provision of all-municipal services; water, sewerage, drainage, electricity, etc. which in turn affects the provision and success of health services.

Innovative thinking is required at all levels, especially to fulfil the National Policy of free and effective Primary Health Care for all the communities, and the subsequent access to state hospital. Upgrading of existing and provision of new hospital facilities must take the economic realities into consideration as well as the position of the densely populated areas. Inner city urban decay is of paramount importance as facilities in these areas are no longer attractive or safe to staff.

The Department of Health requested the CSIR to develop a ***Strategic Plan*** on our behalf for our facilities. The strategic plan is not cast in stone and is a living document that must be revisited and amended, as circumstances require. From this initiative a ***comprehensive Capital Works Plan for Gauteng Health Facilities*** has been compiled. The National Department of Health subsequently appointed consultants to assist the Province to developed a Strategic Position Statement that has been accepted as the Strategic Plan for Gauteng.

Two major and important recent changes will have a vital influence on facilities planning for the Gauteng Department of Health.

- The creation of new large combined metropolitan cities;
- The future transfer of PHC and clinics to local authorities.

Many hospital facilities in Gauteng suffer from a lack of or backlog of maintenance, to both the exterior and interior of buildings including services and equipment. However, the condition of buildings with the exception of a few is reasonable in spite of the age of some building stock (75 years).

The Department of Health has also purchased the PREMIS programme (PROPERTY REAL ESTATE MANAGEMENT INFORMATION SYSTEM) to assist with the consolidation of all the requirements and to give an accurate indication of the maintenance required at each facility.

C) BROAD PROVINCIAL INFRASTRUCTURE INVESTMENT STRATEGY

Capital works expenditure programmes need to be planned for over a period of time (5, 10 and 15 years periods) that can be adjusted in annual budgets.

Facility budget:

Financial year 2001/2002

Firewood and coal:	17 600 000
Fuel and Lubricants:	1 500 000
Specialised Maintenance (Period contracts:	55 000 000
Programmed Maintenance:	86 172 000
Large Capital Projects: (Pretoria Academic)	**50 000 000**
Day-to-Day Maintenance allocated to Institutions:	23 000 000
HR & R Conditional Grant:	**109 000 000**
Emergency:	21 000 000
Infrastructure Conditional Grant:	**16 172 000**
Total:	***346,172,000***

A total of R381,865,562 has been spend.

Financial year 2002/3

BUDGET SUMMARY

New Pretoria Academic Hospital:	70,000,000	
Infrastructure Grant:	31,416,000	
PABX's Radio licenses:	5,000,000	
HR&R:	115,300,000	
Maintenance:	135,273,734	
Day to Day to Institutions:	67,800,683	
Firewood and Coal:	25,500,000	
Fuel and Lubricants:	1,644,000	
Emergency (kept at Central Office):	4,180,598	
Grant Total:		**458,125,281**

MOTIVATION FOR PROJECTS: (? delete, project appear as part of the measurable objectives)

Hospitals where the conditional grants will be used:

Pretoria Academic Hospital - new Hospital

Garankuwa Hospital - New OPD and Casualty and a new **Community Health Centre in Soshanguve Block L** to act as a gateway clinic for the tremendous overloaded Garankuwa OPD. The total Garankuwa Hospital will be revitalised as part of the National process on revitalisation. **Kalafong hospital** - Improve OPD, Casualty and CSSD. This facility is a very large, busy Level 2 and 3 teaching hospital. This hospital seems in many ways to fulfil just as important a role as the Pretoria Academic. Some departments like OPD, Casualty, X-rays and Theatre/CSSD need restructuring and consolidation.

Mamelodi – Building of a New Hospital on the existing Hospital site is a priority and will from part of Revitalisation. The **Stanza Bopape Community Health Centre Phase II** would be completed to assist with the growing increase of population. A much needed CHC in Eersterus will be part of this package to the community on the Eastern Side of Pretoria.

Johannesburg Hospital – General renovation to Pharmacy, Casualty and several wards. This is a very large academic hospital attached to the Wits Medical School. The hospital was designed with separate high-rise blocks linked to each other at ground level by a hospital street. This puts a heavy load on the hospital street. The waiting area at the Pharmacy is completely inadequate and the queue extends into the patient flow areas that are unacceptable. The Development of Differentiated Amenities (Folateng) will form part of this project. The general ward will also be upgraded to assist in the service to the general public. The Fire Audit pointed out serious problems and priority attention will be given to the upgrading of electricity, access control and fire safety. The placement of 250 Level one beds at the Hillbrow CHC site will receive urgent attention.

Leratong Hospital is in a fair condition except for walls that have been clad with vinyl most of which is now falling off. This needs urgent attention as this poses an infection risk. The Casualty and OPD Departments needs restructuring and refurbishment. This project will be the forth revitalisation project and will start as soon as a business plan has been completed and funds have been allocated.

Sterkfontein Hospital is an old established psychiatric hospital with widespread buildings, many in fairly bad condition. Non-habitable wards are to be demolished to ensure safety of the patients whilst the upgrading of wards to conform to latest protocol is required. The building of two new wards on the design of the new wards at Weskoppies will commence during this period.

South Rand Hospital specialises in-patients with CVA's and spinal cases. This facility performs a crucial service for the community south off Johannesburg, which shows definite signs of real urban renewal. The building envelope has integrity and a sound structure but needs minor facility upgrade including the urgent upgrade of the lifts.

Sizwe Tropical Disease Hospital - functions as a chronic TB hospital with a MDR section. Isolation wards for tropical disease do not meet standards and can therefore not be used. Facilities need some upgrading including piped oxygen to wards.

Natalspruit Hospital is a large hospital situated in the midst of a previously very politically unstable community. The hospital has received a "face-lift" and the main hospital corridor is far more user friendly. The dolomite area is not suitable for a hospital as it poses serious Health risks has necessitated the plans to build a new hospital in the Kathorus area, upgrade the Germiston Hospital to a Regional Hospital with a small functioning CHC/district hospital on the current site.

.**Hillbrow** was downsized to a CHC a few years ago and most services moved to Johannesburg Hospital except Oncology. Funds have been allocated to move this speciality to the Johannesburg Hospital. Most buildings on the current site are very old and would need major upgrading or demolishing. However a new Community Health Centre are currently being build on the existing site.

Weskoppies - new wards and upgrading. This facility is a very large psychiatric facility that has been in place for many years, servicing Gauteng and neighbouring Provinces. It is a large site with widespread buildings in various levels of condition. Some upgrading has been done but needs to continue to ensure its effective functioning including the electrical reticulation.

Sebokeng Hospital needs attention to the casualty and OPD and this will commence early in 2003. A Folateng ward for 32 patients will also be established at this site.

Far East Rand Hospital is a very busy hospital in the Far East Rand. It urgently needs upgrade and extension of the maternity section has started during October 2002. The entrance to the hospital is in the process of being upgraded and will ensure easily access.

Proposed spending plan to cover the next five years.

The Department of Health is not considering any Capital Projects from our own budget due to the urgent needs for maintenance accept for the allocation of R5,000,000 for PABX's and Radio licenses.
A comprehensive maintenance plan has been provided and was used for the allocation of the maintenance budget.
This plan will assist in the long term maintenance budgeting provided that it is updated on a regular basis. The allocation to the Institutions directly has increased to ensure participation in the management of maintenance and quicker response times to day-to-day maintenance.

C) MANAGEMENT OF THE CONDITIONAL GRANTS.

The projects on the list have been identified by Health as the major priorities after consultation with all the role-players including the Department of Transport of Public Works.

The Department of Health will release an advance of 3 months money to the Department of Transport and Public Works and will release more according to the expenditure and monthly accounts received. The list provided has a contingency plan build into it to allow for any slippage's as the Department of Transport and Public Works has a history of not spending the money during the financial year.

- As a **Pilot project** the total budget of the following Institutions will be released to them for monitoring and payment of all accounts/fees:

Region A: Carltonville Hospital
Sizwe Hospital

Region B: Far East Rand Hospital
Tembisa Hospital

Region C: Weskoppies Hospital
Garankuwa Hospital

This will ensure that the accountability is with the Institution and the commitment to ensure the steadily implementation is instilled in this process.

Regular monitoring meetings are held every month with the Regional Works office and all the Institutions to ensure that the necessary steps can be taken to rectify problems as they arise. A overall budget meeting will also be held with the Management of the Department of Public Transport Roads and Works to discuss broader issues.

Capital works expenditure programmes need to be planned over a period of time (5, 10 and 15 years periods) that can be adjusted in annual budgets. At March 2001 costs, a total budget for upgrading, restructuring and building of new hospitals as listed is estimated at R964,4 million.

REVITALISATION PROJECTS

Revitalisation includes a total (comprehensive) change in the management of the Institution including:

- Infrastructure
- Health Technology
- Organisational Development
- Quality of Care
- Emergency Medical Services.

It must be in line with the provincial priorities for sustainable service delivery as identified in the provinces' Strategic Position Statement. (SPS)

The main criteria used for inclusion into this project is that the Province must have the capacity and preparedness to transform and modernise the hospital sector in line with nationally agreed goals and timeframes.

The Revitalisation programme has very strict criteria that must be adhered to. Due to the under expenditure various projects had to be included to ensure the best possible solutions for the Gauteng facilities. A total of 228 projects will be implemented over the next three years. The New Pretoria East Hospital (Mamelodi) will be funded as part of the revitalisation programme whilst Phase two of the Stanza Bopape Clinic form part of this project

Chris Hani Baragwanath and **Stretford Community Health Centre:** The Chris Hani Baragwanath Hospital is the largest of all the Gauteng hospitals and serves the whole of greater Soweto and a large part of Southern Gauteng. It is also a referral hospital in many instances for all Gauteng hospitals and cross border hospitals. The size, extent and layout of the site make management, maintenance, supervision and control extremely difficult. This hospital however is perceived as a national asset, with its excellent research and teaching component as well as medical track record. It is entrenched as an institution of note with a national and international reputation. Cost centres for various departments have been established under one central management to ease management and control over this large and diverse site. New OPD/Casualty and Phase 2 of Stretford Community Health Centre will assist with the overload at Chris Hani Baragwanath OPD. This project will also be funded by the Revitalisation fund and will include a new District Hospital for the Southern part of Soweto and one or two CHC to be built or expansion of the current inadequate facilities.

Natalspruit Hospital is a large hospital situated in the midst of a previously very politically unstable community. The hospital has received a "face-lift" and the main hospital corridor is far more user friendly. The dolomite area is not suitable for a hospital as it poses serious Health risks has necessitated the plans to build a new hospital in the Kathorus area, upgrade the Germiston Hospital to a Regional Hospital with a small functioning CHC/district hospital on the current site.

MAINTENANCE BUDGET REQUIRED

The maintenance budget is based on the condition based assessments recently completed by the CSIR. The Department of Health has introduced a very vigorous decentralisation programme of the Day-to-Day to the various Institutions and Health Regions. It is anticipated that a larger allocation will be made to the Institutions for the 2002/3 financial year. Extensive training and capacity building programmes are currently undertaken and will assist the Institutions with the effective and efficient implementation of the Day-to-Day Maintenance. A budget of R214,397,455 is required for the 2002/3 financial year and R235,094,032 for the 2003/4 financial year.

8.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Strategic Objectives	Measurable Objectives	Indicator[1]	2001/02 (actual)[2]	2002/03 (estimate)[2]	2003/04 (target)	2004/05 (target)	2005/06 (target)
Construction, refurbishment and maintenance of infrastructure and equipment	Complete phase 2 New Pretoria Academic Hospitals	Percentage completed	To be provided		90	100	-
	Construction of Hillbrow Community Health Centre	Percentage completed			50	100	-
	Construction of New Mamelodi Hospital	Percentage completed			40	80	100
	Construction of Stanza Bopape Community Health Centre: Phase 2	Percentage completed			50	90	100
	Construction of Soshanguve Block L Community Health Centre	Percentage completed			70	90	100
	Construction of Sterkfontein Hospital 2 new wards at	Percentage completed			20	50	80
	Construction of Weskoppies Hospital New wards	Percentage completed			100	-	-
	Construction of Sizwe Hospital new kitchen, ventilation and electrical ringfeed	Percentage completed			70	100	-
	Construction of Stretford Community Health Centre: Phase 2	Percentage completed			70	100	-

	Construction of Total revitalization of Chris Hani Baragwananth Hospital	Percentage completed			30	50	70
	Construction of New District Hospital for Johannesburg South Area	Percentage completed			30	50	100
	Upgrading of existing and new Community Health Centres in CHD catchment area	Percentage completed			20	50	70
	Relocation of Natalspruit Hospital	Percentage completed			20	50	80
	Renovation of OPD and Casualty Kalafong Hospital	Percentage completed			40	100	-
	Renovation of OPD and Casualty Tembisa Hospital	Percentage completed			40	70	100
	Renovation of OPD and casualty Sebokeng Hospital	Percentage completed			50	80	100
	Renovation of OPD and casualty Leratong Hospital	Percentage completed			20	5o	80
	General upgrading of Johannesburg Hospital: Pharmacy, Casualty and several Wards	Percentage completed			30	70	100
	Upgrading of Maternity Ward at Far East Rand Hospital	Percentage completed			60	100	-

8.6 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Table: Evolution of expenditure by budget programme and sub-programme in current prices (R million)

Academic Hospitals: Pretoria Academic Hospital

Sub-programme	2000/01 (actual)	2001/2 (actual)	2002/3 (estimate)	2003/4 (budget)	2004/05 (MTEF projection)	2002/06 (MTEF projection)
Capital					7 000*	10 000*
Maintenance (current)			13 500	14 900	30 000	29 000
Conditional Grant New Pretoria Academic Hospital			70 000 36 000	90 000		
Conditional Grant (Infrastructure)*			1 000	1 000		

*** Rehabilitation to old PAH to District Hospital**

Table: Evolution of expenditure by budget programme and sub-programme in current prices (R million)

Academic Hospitals: Chris Hani Baragwanath Hospital including: Laundry and Nursing College

Sub-programme	2000/01 (actual)	2001/2 (actual)	2002/3 (estimate)	2003/4 (budget)	2004/05 (MTEF projection)	2002/06 (MTEF projection)
Maintenance (current)			24 288	40 627	42 497	38 718
Revitalisation			5 000	50 000	150 000	250 000
Total			29 288	90 627	192 497	288 718

Table: Evolution of expenditure by budget programme and sub-programme in current prices (R million)

Academic Hospitals: Garankuwa Hospital

Sub-programme	2000/01 (actual)	2001/2 (actual)	2002/3 (estimate)	2003/4 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)
Capital						
Maintenance (current)			13 899	5 000	6 000	8 000
HR&R		4 000	11 972			
Revitalisation				10 000	20 000	30 000
Conditional Grant			500			

(Infrastructure)						
Total			13 899	15 000	26 000	38 000

Table: Evolution of expenditure by budget programme and sub-programme in current prices (R million)

Academic Hospitals: Johannesburg Hospital including Laundry

Sub-programme	**2000/01 (actual)**	**2001/2 (actual)**	**2002/3 (estimate)**	**2003/4 (budget)**	**2004/05 (MTEF projection)**	**2002/06 (MTEF projection)**
Capital				7 000	2 000	10 000
Maintenance (current)			26 949	35 582	37 718	39 518
Grant (HR&R)		28779	62167			
Conditional Grant (Infrastructure)			8000	10 000	8 000	
Total						

Table: Evolution of expenditure by budget programme and sub-programme in current prices (R million)

Specialised Institutions

Sub-programme	**2000/01 (actual)**	**2001/2 (actual)**	**2002/3 (estimate)**	**2003/4 (budget)**	**2004/05 (MTEF projection)**	**2002/06 (MTEF projection)**
Capital				7 000	5 000	2 000
Maintenance (current)			31 915	24 804	31 804	26 733
HR&R			18716			
Conditional grant			900	2.000	4.000	
Revitalisation						
Total						

cash flow

Table: Evolution of expenditure by budget programme and sub-programme in current prices (R million)

Regional Hospitals

Sub-programme	**2000/01 (actual)**	**2001/2 (actual)**	**2002/3 (estimate)**	**2003/4 (budget)**	**2004/05 (MTEF projection)**	**2002/06 (MTEF projection)**
Capital				44 000	20 000	9 000
Maintenance (current)			103 615	89 182	81 954	90 280
HR&R		24380	41848			
Revitalisation						
Conditional Grant (Infrastructure)			2614	10 000	8 000	5 000

Table: Evolution of expenditure by budget programme and sub-programme in current prices (R million)

District Hospitals

Sub-programme	2000/01 (actual)	2001/2 (actual)	2002/3 (estimate)	2003/4 (budget)	2004/05 (MTEF projection)	2002/06 (MTEF projection)
Capital						
Maintenance (current)			27 490	22 524	27 039	21 701
Revitalisation					40 000*	60 000*
HR&R			16 808			
Conditional Grant (Infrastructure)				2 000	5 000	
Total			27 490	24 524	73 039	81 701

*** New Tshwane Eastern Hospital**

*** Upgrading of Germiston Hospital to a Regional Hospital**

Table: Evolution of expenditure by budget programme and sub-programme in current prices (R million)

Other Health Facilities *

Sub-programme	2000/01 (actual)	2001/2 (actual)	2002/3 (estimate)	2003/4 (budget)	2004/05 (MTEF projection)	2002/06 (MTEF projection)
Capital				17 000	13 000	16 000
Maintenance (current)			17 968	49 566	61 056	52 155
Conditional Grant (HR&R / Revitalisation)			7 500	14 000		
Conditional Grant (Infrastructure)				15 000	10 000	
Zivuseni**			15 000	45 000	50 000	
Total			27 968	96 566	84 056	68 155

*** Other facilities include: Laundries, Nursing Colleges, Mortuaries, Emergency services, Cook freeze and Primary Health Care.**

** The Gauteng Provincial Government has set aside R1 billion over the next five years to alleviate the scourge of poverty in impoverished local communities in the Province. The aim is to mobilise local communities to take ownership of their lives in the renewal of community assets. There will also be skills transfer to the poor and unemployed in the various targeted areas. The programme will target Primary Health Care Facilities and non heal

NB: Information for the tables below is still being verified, will be provided with the final strategic plan

Table: Facility construction, upgrades and rehabilitation (R '000)*

New construction	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)	Total project estimate
Programme 1 total							----
Programme 2 total							----
- Project 1							
- Project 2							
Programme 3 total							----
- Project 1							
- Project 2							
etc							
Total new construct.							----
Upgrading/rehab.							
Programme 1 total							----
Programme 2 total							----
- Project 1							
- Project 2							
Programme 3 total							----
- Project 1							
- Project 2							
etc							
Total upgrading and rehabilitation							----

*If not funded from the provincial budget, details should be presented in separate note. In addition to programme totals, individual projects at or above a value of R25m should be presented separately. Conditional grant expenditure should be identified where possible.

Table: Facility maintenance (R '000)

Maintenance	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)
Programme 1 Programme 2 Programme 3 etc						
Total						
Total as % of provincial health expenditure/budget						

Table: Medical equipment purchase and maintenance (R '000)

Equipment purchase	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)
Programme 1 Programme 2 Programme 3 Etc						
Total purchase						
Total maintenance						
Maintenance as % of provincial health expenditure/budget						